Extraordinary NWSSP Audit Committee Meeting , Part A

Mon 15 June 2026, 13:00 - 14:00

By Microsoft Teams

Meeting Chaired by Gareth Jones

Agenda

13:00 - 13:05
5 min

1. Standard Business

Information *Gareth Jones, Chair*

1.1. Welcome and Introductions

Information *Gareth Jones, Chair*

1.2. Apologies

Information *Gareth Jones, Chair*

1.3. Declarations of Interest

Information *Gareth Jones, Chair*

13:05 - 13:40
35 min

2. Internal Audit

2.1. Internal Audit Progress Report

Discussion/Noting *James Johns, Head of Internal Audit and Assurance Services*

A&A NWSSP Audit Cttee Progress Report June 26 .pdf (7 pages)

2.2. Internal Audit Reports

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

2.2.1. Procurement Services: Single Tender Action's and Declarations of Interest

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

SSP-2526-04 Procurement Services STAs & DOIs Final Internal Audit Report.pdf (8 pages)

2.2.2. Health Courier Services - Vehicle Management

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

SSP-2526-05 HCS Vehicle Management Final IA Report .pdf (10 pages)

2.2.3. Recruitment and Retention

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

SSP-2526-10 Recruitment & Retention - Final Internal Audit Report.pdf (6 pages)

2.2.4. Capital - Radiopharmacy phase 2

Discussion/Noting *David Butler, Audit Manager*

SSP-SSU-2526-17 Final Internal Audit Report - SE Radiopharmacy.pdf (19 pages)

2.2.5. Budget Setting

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

SSP-2526-09 Budget Setting - Final Report.pdf (6 pages)

2.3. NWSSP Head of Internal Audit Opinion and Annual Report 2025-26

Discussion/Noting *James Johns, Head of Internal Audit and Assurance Services*

A&A NWSSP HIA Opinion and Annual Report 2025-26 FINAL2.pdf (22 pages)

13:40 - 14:00
20 min

3. Governance and Assurance

3.1. Draft 2025-26 NWSSP Annual Governance Statement (AGS)

Decision *James Quance, Assistant Director of Corporate Services*

NWSSP Audit Committee - NWSSP Annual Governance Statement 2025-26 Cover Paper 15 June 2026.pdf (3 pages)
Appendix 1 - NWSSP Annual Governance Statement 2025-26.pdf (42 pages)

14:00 - 14:00
0 min

4. Any Other Business

Verbal *Gareth Jones, Chair*

- *Nothing received at the time of writing*

14:00 - 14:00
0 min

5. Date and Time of Next Meeting on 7 July 2026, from 2 to 4 pm, in person at IP5

Information *Gareth Jones, Chair*

NHS WALES SHARED SERVICES PARTNERSHIP

Audit Committee

June 2026

Audit & Assurance Services
Internal Audit Progress Report

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4.	Other Internal Audit Activity and Engagement	3

Appendix A - Assignment Status Schedule 2025-26

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

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

ASSIGNMENT	ASSURANCE RATING
Budget Setting	Substantial
NWSSP Recruitment & Retention	Substantial
Procurement – Single Tender Actions and Declaration of Interest	Reasonable
Health Courier Service Vehicle Management	Reasonable
Southeast Wales Radiopharmacy	Reasonable
Cyber Security Governance Arrangements	Limited

3. Delivery and Planning Update

Following the finalisation of the reports highlighted in the table above, the Annual Report & Opinion for 2025/26 has been issued providing Reasonable Assurance overall opinion. This report is included separately on the Committee Agenda.

One audit from the 2025/26 plan, Medical Examiner Service, remained at working in progress at this stage primarily as result of challenges in agreeing to the information required to be provided for part of the audit. This does not impact on the overall opinion.

The audit status schedule highlighting progress with the delivery of the Internal Audit Plan for 25/26, is shown in Appendix A.

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 - 2025/26 Internal Audit Plan

Audit	Status	Assurance Rating	Matters Arising		Timing	Audit Committee
			H	M		
Primary Care Services- General Ophthalmic Services	FINAL	Substantial	-	1	Q1/2	November
Risk Management	FINAL	Reasonable	1	1	Q2	November
Accounts Payable	FINAL	Reasonable	-	3	Q1/2	November
Radiopharmacy (1)	FINAL	Reasonable	-	10	Q1/2	November
TRAMS Digital	FINAL	Reasonable	1	2	Q2/3	Feb
SES Targeted Estates Funding	FINAL	Substantial		2	Q2	Feb
Single Lead Employer	FINAL	Reasonable	1	-	Q2/3	Feb
Payroll	FINAL	Substantial	-	1	Q2-4	Feb
Digital Strategy	FINAL	Reasonable	-	4	Q3/4	Apr
Cyber	**FINAL**	**Limited**	**2**	**1**	**Q2/3**	**June**
Health Courier Services – Vehicle Management	**FINAL**	**Reasonable**	**-**	**5**	**Q3**	**June**
Procurement Services – Single Tender Actions and Declaration of Interests	**FINAL**	**Reasonable**	**1**	**3**	**Q3/4**	**June**

Audit	Status	Assurance Rating	Matters Arising		Timing	Audit Committee
			H	M		
Budget Setting	**FINAL**	**Substantial**	**-**	**1**	**Q2/3**	**June**
NWSSP Recruitment & Retention	**FINAL**	**Substantial**	**-**	**--**	**Q3/4**	**June**
Radiopharmacy (2)	**FINAL**	**Reasonable**	**-**		**Q3/4**	**June**
Medical Examiner Service	**wip**				**Q3/4**	
~~Regulatory Compliance~~	~~defer~~					
Agreed Action Follow up	Completed					

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Procurement Services: Single Tender Actions & Declarations of Interest

Final Internal Audit Report

2025/26

NHS Wales Shared Services Partnership

Reasonable Assurance

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Review Reference	SSP-2526-04
Fieldwork	December 2025 – May 2026
Executive Sign Off	22 May 2026
Audit Committee	15 June 2026
Executive Lead	Jonathan Irvine, Director of Procurement & Health Courier Services
Audit Team	James Johns, Head of Internal Audit Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the adequacy and effectiveness of the control arrangements governing Single Tender Actions (STAs) and Declarations of Interest (DOIs).

Overview

Policies and procedures are aligned to regulatory requirements although there is opportunity to better define the processes, controls and documentation requirements specifically in relation to STAs. Sample testing identified instances where approval had not been obtained in line with SFIs and evidence was not available to demonstrate full compliance with key regulatory and policy requirements in relation to both STAs and DOIs.

A Procurement Toolkit was developed in early 2025 to ensure that procurement activities are carried out efficiently, transparently and in compliance with policies and regulations. The toolkit is well designed, but sample testing found that it isn't widely utilised or effective in ensuring compliance with regulatory requirements. Consistent and effective embedding of the toolkit across procurement activity is a critical enabler in addressing the compliance issues identified throughout this review.

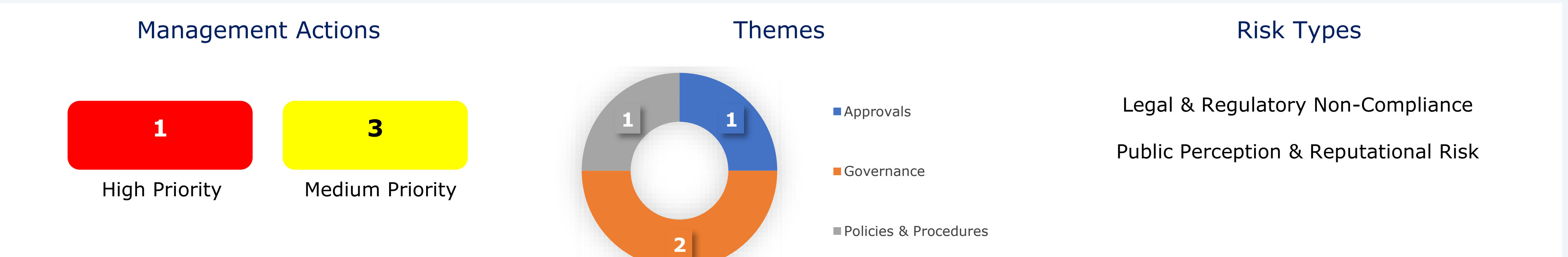
We have concluded **Reasonable** assurance on this area. We have identified four findings requiring management action:

- Greater clarity is required regarding the STA process, controls and documentation requirements **[Finding 1]**
- The STA form does not align to approval requirements stipulated within SFIs and instances were identified where approvals were not in line with SFIs, although clarification is required regarding delegated authority in this regard. **[Finding 2]**
- Evidence was not always available to demonstrate compliance with the requirement to publish UK5, UK6 and UK7 notices in line with the Procurement Act 2023. We recognise that our testing period has coincided with a period of transition to the new regulations. **[Finding 3]**
- Instances where DOIs had not been fully or correctly completed. **[Finding 4]**

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	STAs are undertaken in accordance with the requirements of the *Health Services (Provider Selection Regime) (Wales) Regulations 2025* and *Procurement Act 2023 and* are subject to appropriate scrutiny and approval to ensure that they are by exception and demonstrate appropriate rationale.	1, 2, 3	**Reasonable**
2	Potential conflicts of interest are identified, recorded and mitigated for all individuals involved in or with influence over the procurement process, to ensure integrity and transparency of decision-making.	4	**Reasonable**



Management Actions
1
High Priority
3
Medium Priority
Themes
1
1
2
Approvals
Governance
Policies & Procedures
Risk Types
Legal & Regulatory Non-Compliance
Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: STAs are undertaken in accordance with the requirements of the *Health Services (Provider Selection Regime) (Wales) Regulations 2025* and *Procurement Act 2023,* and are subject to appropriate scrutiny and approval to ensure that they are by exception and demonstrate appropriate rationale	**Reasonable**

Procedural Guidance

The Health Services (Provider Selection Regime) (Wales) Regulations 2025[1] (the 'PSR') and the *Procurement Act 2023*[2] (the 'Act') set out the circumstances where an STA or direct award is permitted and stipulate the mandatory requirement to publish a series of prescribed notices for procurements above the regulatory threshold. Both place emphasis on transparency and the requirement to maintain an audit trail to justify the chosen route. The Procurement Services Document Management System (DMS) is aligned to the requirements of both the PSR and Act, although it is not explicit regarding the specific process, controls and documentation requirements for STAs. **[Finding 1]**

A Procurement Toolkit was developed in early 2025 to ensure that procurement activities are carried out efficiently, transparently and in compliance with policies and regulations. The toolkit contains gateway review to ensure that all tasks have been completed, checked and approved before proceeding to the next step of the procurement process. The toolkit is well designed, but sample testing found that it isn't widely utilised or effective in ensuring compliance with regulatory requirements – see below.

Compliance with the PSR/Act and the DMS

In the absence of definitive guidance within the DMS on STA requirements **[Finding 1]**, we have assessed compliance with the key requirements of the PSR/Act and key internal controls as identified by and agreed with management. We sampled 30 STAs completed since February 2025 - all had a fully completed STA form or equivalent demonstrating the rationale for the STA route.

Model Standing Financial Instructions (SFIs) stipulate that *the Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000.* This requirement is not reflected in the all-Wales STA template which only requires one approval from the *Chief Executive or Director of Finance or Director of Strategy or Chief Operating Officer*. In some cases, the template form had been amended to capture the dual approval whilst in others there was evidence of delegation from the CEO to the DoF (although this practice still falls short of the dual approval required by SFIs). Eight STAs exceeding £25,000 had only been approved by the DoF and a further two had been authorised by a Head of Finance (or equivalent). All instances were within the same procurement team. 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. **[Finding 2]**

Seven procurements reviewed did not have evidence to demonstrate full compliance with the requirements to publish notices on Sell2Wales, and in one case a notice had been published retrospectively. Contract award letters were not available for six STAs. **[Finding 3]**

The Procurement Toolkit had not been used for nine of the 30 sampled STAs. Some were incomplete and sample testing has demonstrated that the toolkit is not being utilised effectively to improve compliance. **[Finding 3]**

Compliance with declaration of interest requirements is covered in objective 2 below.

[1] Applicable to the procurement of health services.

[2] Applicable to all other procurements.

	Key Findings	Risk & Impact	Agreed Management Action
1	**STA Documentation Requirements** Procurement Services has developed a standard STA form and procurement toolkit to support compliance with the relevant Regulations and the Act. However, the Document Management System (DMS) does not clearly define the specific controls or documentation standards required when completing an STA.	Breach of Standing Orders, Standing Financial Instructions or regulatory requirements which could result in legal challenge, reputational damage and/or financial loss.	**Agreed Action:** The DMS will be refined to provide greater clarity on the requirements for STAs.
			Expected Evidence of Implementation: Updated DMS.
		Medium Priority	**Officer:** Jonathan Irvine, Director of Procurement & Health Courier Services
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 01.06.26
2	**STA Approvals** 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. 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. 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.	Breach of Standing Orders, Standing Financial Instructions or regulatory requirements which could result in legal challenge, reputational damage and/or financial loss.	**Agreed Action:** STA approval delegations will be confirmed with health bodies. 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.
			Expected Evidence of Implementation: Email correspondence from health bodies confirming STA approval delegation arrangements. Email correspondence from WG clarifying the requirement for dual approval of STAs over £25k. Updated STA template subject to the clarification provided by WG.
		High Priority	**Officer:** Jonathan Irvine, Director of Procurement & Health Courier Services
	Theme: Approvals	Control Design	**Target Implementation Date:** 30.06.26

3	**Missing / Incomplete Documentation - STAs** Seven of the 30 STAs reviewed did not have evidence to demonstrate full compliance with the requirement to publish notices (UK5, UK6 & UK7) on Sell2Wales. Contract award letters were not available for six STAs. The Procurement Toolkit had not been used for nine of the 30 sampled STAs. Some were incomplete and sample testing has demonstrated that the toolkit is not being utilised effectively to improve compliance.	Breach of Standing Orders, Standing Financial Instructions or regulatory requirements which could result in legal challenge, reputational damage and/or financial loss.	**Agreed Action:** As per finding 1, the DMS will be refined to provide greater clarity on the requirements for STAs. Checks will be undertaken (100% initially, reducing as compliance improves) to confirm that the procurement toolkit is being utilised for all procurement exercises and any instances of non-compliance with regulatory/DMS requirements are being identified and addressed via the toolkit gateway reviews.
			Expected Evidence of Implementation: Record of checks undertaken.
		Medium Priority	**Officer:** Jonathan Irvine, Director of Procurement & Health Courier Services
	Theme: Governance	Control Operation	**Target Implementation Date:** 30.06.26

Objective 2: Potential conflicts of interest are identified, recorded and mitigated for all individuals involved in or with influence over the procurement process, to ensure integrity and transparency of decision-making	Reasonable

The DMS sets out the requirements for completing declarations of interest (DOIs) under both PSR Wales and Procurement Act 2023. DOI forms must be obtained, kept up to date, saved in the relevant contract folder, and recorded on the conflicts-assessment tab within the Procurement Toolkit.

Fieldwork was undertaken to assess compliance with DOI requirements across a sample of 51 procurement exercises – the 30 STAs reviewed under objective 1 and an additional 21 procurements. One procurement had no evidence that DOIs had been obtained and a further 15 procurements had DOIs for some but not all stakeholders. **[Finding 4]**

A total of 150 DOIs were present for the remaining 50 procurements, and the prescribed DOI template was used consistently across the sample. In some cases, the conflicts assessment tab of the toolkit had not been completed to identify the stakeholders involved in the procurement exercise, so we were unable to determine whether DOIs had been obtained from all stakeholders. **[Finding 4]**

Nineteen DOIs had no evidence of independent review by Procurement to ensure no conflicts existed, although no conflicts had been declared on any. A further seven had been signed and dated as reviewed by Procurement before the date of the stakeholder declaration. **[Finding 4]**

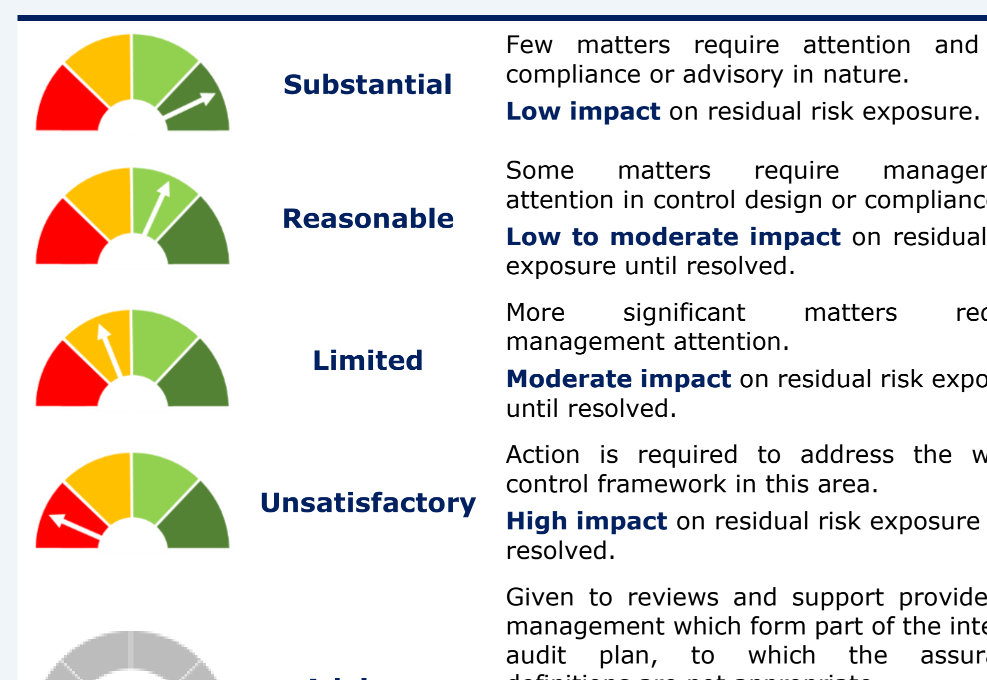
Nine DOIs (across six procurements) had not been fully completed, and fifteen (across nine procurements) had been completed retrospectively. **[Finding 4]**

Failure to ensure full compliance with DOI requirements may undermine the transparency and integrity of the procurement process as the organisation may not be able to demonstrate that actual or potential conflicts of interest have been identified, assessed and appropriately managed. There is a risk that procurement decisions may be influenced — or perceived to be influenced—by personal, financial, or professional interests.

Key Findings		Risk & Impact	Agreed Management Action
4	**Declarations of Interest Documentation** Testing across a sample of 51 procurement exercises identified one procurement where there was no evidence that DOIs had being obtained, and a further 15 procurements had incomplete coverage, with declarations not in place for all stakeholders. While 150 DOIs were identified across the remaining 50 procurements and the prescribed template was used consistently, the conflicts assessment tab within the Procurement Toolkit was not always completed, limiting assurance that all stakeholders had been identified. Nineteen DOIs had no evidence of review by Procurement, and a further seven had been signed and dated prior to the stakeholder declaration, undermining the validity of the review process. In addition, nine DOIs were incomplete and fifteen were completed retrospectively, indicating that declarations were not always obtained at the appropriate stage in the procurement process.	Breach of Standing Orders, Standing Financial Instructions or regulatory requirements which could result in legal challenge, reputational damage and/or financial loss. **Medium Priority**	**Agreed Action:** Declarations of Interest are obtained from all relevant stakeholders and procurement at the appropriate stage of the procurement exercise/process, fully completed, recorded within the Procurement Toolkit, and independently review by Procurement. *See also finding / action 3 regarding procurement toolkit compliance checks.* **Expected Evidence of Implementation:** Record of checks undertaken. **Officer:** Jonathan Irvine, Director of Procurement & Health Courier Services
	Theme: Governance	Control Operation	**Target Implementation Date:** 30.06.26

Appendix A

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the 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 the 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]

Health Courier Services: Vehicle Management

Final Internal Audit Report

2025/26

NHS Wales Shared Services Partnership

Reasonable Assurance

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Review Reference	SSP-2526-05
Fieldwork	January – April 2026
Executive Sign Off	29 May 2026
Audit Committee	15 June 2026
Executive Lead	Jonathan Irvine, Director of Procurement & Health Courier Services
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

NHS Wales Health Courier Service (HCS) supports front line services across Wales, operating where required 24 hours a day, 365 days a year providing vital Clinical Logistical Support services for Primary and Unscheduled Care in Hospitals, Clinics, Surgeries, GP Practices, Pharmacies, Schools (Immunisation programmes) etc.

HCS employs 302 staff members across 16 sites. It has 288 vehicles covering 380+ schedules in excess of 2.6m miles annually, transporting pathology, medicines, and medical records. This audit has reviewed and assessed arrangements in place for vehicle management.

Overview

Weaknesses were identified in the governance and oversight of vehicle management, with the absence for formal policies and procedures for fleet management and no single reliable mechanism to provide oversight and assurance in relation to vehicle compliance. Our testing found that vehicles are compliant with servicing, maintenance, MOT and tax requirements, although supporting evidence to demonstrate this wasn't always readily accessible particularly for leased vehicles.

Vehicle incidents are reported, investigated and closed promptly. However, there is limited evidence of feedback to relevant parties and the sharing of learning to prevent recurrence. There is limited oversight of insurance claims and the volume/value of vehicle repairs.

We have concluded **Reasonable** assurance overall, with five medium priority findings relating to:

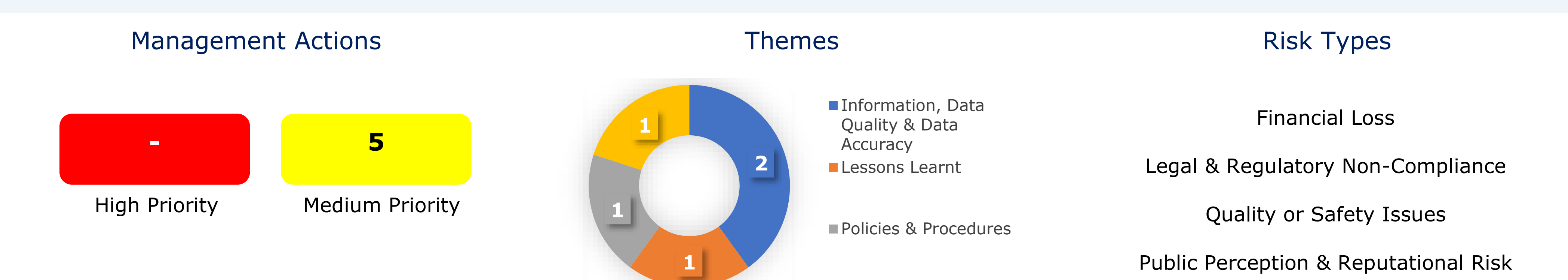
- Policies and procedures
- Fleet management systems
- Daily vehicle checks
- Post investigation feedback and lessons learned
- Insurance claims and costs associated with vehicle incidents

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

Scope & Assurance Summary

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

	Objectives	Related Findings	Assurance
1	There are effective processes in place including planned maintenance programmes and regular vehicle check requirements to ensure vehicles remain safe, roadworthy and compliant with regulatory requirements.	1, 2, 3	**Reasonable**
2	Vehicle related incidents are captured on Datix and subject to thorough investigation, with action taken and lessons learned shared across the service to minimise the risk of recurrence.	4, 5	**Reasonable**


Management Actions
-
High Priority
5
Medium Priority
Themes
2
1
1
1
Information, Data Quality & Data Accuracy
Lessons Learnt
Policies & Procedures
Risk Types
Financial Loss
Legal & Regulatory Non-Compliance
Quality or Safety Issues
Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: There are effective processes in place including planned maintenance programmes and regular vehicle check requirements to ensure vehicles remain safe, roadworthy and compliant with regulatory requirements	**Reasonable**

Policies/Procedures

There are no policies or procedures in place relating to vehicle management and maintenance or the arrangements for ensuring compliance with regulatory requirements. **[Finding 1]**

At the outset of the audit there were no maintenance schedules in place for each vehicle setting out the maintenance/safety/compliance checks required. This was highlighted to management and promptly addressed – a Fleet Compliance Requirements Matrix is now in place identifying the servicing and maintenance requirements for owned and hired vehicles, the frequency/timing of these, required evidence and source. There is opportunity to further enhance the matrix with clear cross referencing to the requirement source – e.g. regulatory requirement or internal policy.

Vehicle Maintenance Service Providers

Maintenance and servicing of HCS vehicles is outsourced to Welsh Ambulance Services University NHS Trust (WAST) for business owned fleet, and four private contractors for leased and electric vehicles. There is an SLA in place with WAST which commenced in 2015 and automatically renews every 12months unless terminated. Maintenance for leased vehicles forms part of the lease arrangements.

Fleet Management System

Maintenance records for owned vehicles are captured on the WAST Chevin system. The FleetCheck system was introduced to provide a single central source of maintenance records for all vehicles including leased. However, this is reliant on the manual population of service/maintenance data from Chevin and leased vehicle contractors. FleetCheck has not been kept up to date due to absence within the Fleet team and therefore is not a reliable tool for providing oversight and assurance in relation to vehicle compliance. **[Finding 2]**

All owned vehicles on the Chevin system were confirmed to be up to date with MOT and servicing and tax requirements based on the information recorded within the system. More detailed testing on a sample of 20 vehicles (owned and leased) confirmed that evidence was available to confirm servicing, MOT and tax compliance (including servicing of tail lift and temperature-controlled units, where applicable). For leased vehicles the servicing evidence was not readily available and had to be requested from the contractor for the purpose of the review. **[Finding 2]**

Daily Vehicle Checks

Vehicle checks are required to be completed by all drivers at the start and end of each shift, with completion prompted and recorded via handheld PDAs before schedules can commence. However, incident data indicates that, despite checks being recorded as complete, they are not consistently undertaken or completed to the required standard. **[Finding 3]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Policies / Procedures** There are no documented policies and procedures in place relating to vehicle management and maintenance or the arrangements for ensuring compliance with regulatory requirements. A good example of a fleet management policy might include: • Roles and responsibilities • Legal and regulatory requirements • Maintenance & servicing regimes (now captured in the Fleet Compliance Requirements Matrix) • Vehicle checks • Defect and incident/accident reporting • Systems for record keeping and monitoring compliance • Fleet monitoring and performance • Environmental and sustainability considerations	Non-Compliance with statutory and organisational requirements potentially resulting in harm to staff/ public, financial penalty and reputational damage.	**Agreed Action:** Vehicle management and maintenance arrangements will be formally documented and disseminated with the relevant teams for their reference i.e. Fleet Team and HCS Management Teams, defining what responsibilities lie with each team. Recently appointed Regional Manager (Fleet) has started to create a library of Standard Operating Procedures (SOPs) aligned to the roles and responsibilities of the HCS Fleet Team and, in conjunction with HCS Management Teams, will determine the SOPs required to maintain operational compliance.
			Expected Evidence of Implementation: Documented and controlled procedures for fleet management and maintenance.
		Medium Priority	**Officer:** Regional Manager (Fleet) **Target Implementation Date:** w/c 29th June 2026 - Draft versions shared for wider HCS Management comment. w/c 10th August 2026 – Approved versions issued.
	Theme: Policies & Procedures	Control Design	
2	**Fleet Management Systems** 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. 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 organisational requirements relating to servicing, MOT, tax and safety inspections. 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.	Non-Compliance with statutory and organisational requirements potentially resulting in harm to staff/ public, financial penalty and reputational damage.	**Agreed Action:** 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. 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.
			Expected Evidence of Implementation: Rationalisation of fleet systems enabling access to accurate data applicable to the vehicle requirements when required to evidence compliance with statutory and regulatory standards.

		Medium Priority	**Officer:** Regional Manager (Fleet) & Regional Manager (ABUHB)
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** 31st March 2027 (Dependant on budget availability and procurement timelines).

3	**Daily Vehicle Checks** 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.	Vehicle safety and reliability may be compromised, potentially resulting in service disruption and/or harm to staff/ public, financial penalty and reputational damage.	**Agreed Action:** 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. 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. Existing daily vehicle checks are being strengthened with a review of resource management functionality within the logistics planning platform (Cleric). 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. 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.
			Expected Evidence of Implementation: More robust mechanisms for the completion and review of daily vehicle checks – SOP and Cleric evidence 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. Dependant on logistics planning platform version developments in late Summer/early Autumn 2026, using photographic evidence to support daily vehicle check auditing.
		Medium Priority	**Officer:** Regional Manager (with systems responsibility)

	Theme: Training & Development	Control Operation	Target Implementation Date: w/c 26th October 2026

Objective 2: Vehicle related incidents are captured on Datix and subject to thorough investigation, with action taken and lessons learned shared across the service to minimise the risk of recurrence — Reasonable

The driver handbook sets out the procedure to follow when an incident occurs and includes Datix reporting requirements. This also includes a set of flashcards so employees can see the processes required at a glance and are available within the content locker of drivers PDA for immediate accessibility.

A total of 344 incidents were reported within Health Courier Services (HCS) during the period April 2024 to December 2025, of which 65% related to damage to vehicles. The majority of vehicle-related incidents were reported in a timely manner; however, a small proportion (11%) were not reported within the required three working days. Notwithstanding this, almost all incidents were reported within five working days. All incidents were assessed as resulting in either no harm or low harm following investigation. No overdue open incidents were identified at the time of our review. The average time taken to close an incident is 28 working days.

Detailed testing of a sample of 20 incidents confirmed that all had been subject to appropriate investigation although gaps in evidence to demonstrate feedback to relevant parties and the identification and sharing of learning. 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. **[Finding 4]**

A record of vehicle insurance claims is not maintained, although this information is available from the insurer. Vehicle repairs under £1000 do not go through insurance and are paid for instead. We were unable to quantify the volume or value of these repairs as this information is not centrally recorded or monitored. **[Finding 5]**

During 2025, 66 claims were submitted to the insurer; six of these could not be matched to a corresponding incident report on Datix – four incidents had been recorded with incorrect vehicle registration and two required recording on Datix. **[Finding 5]**

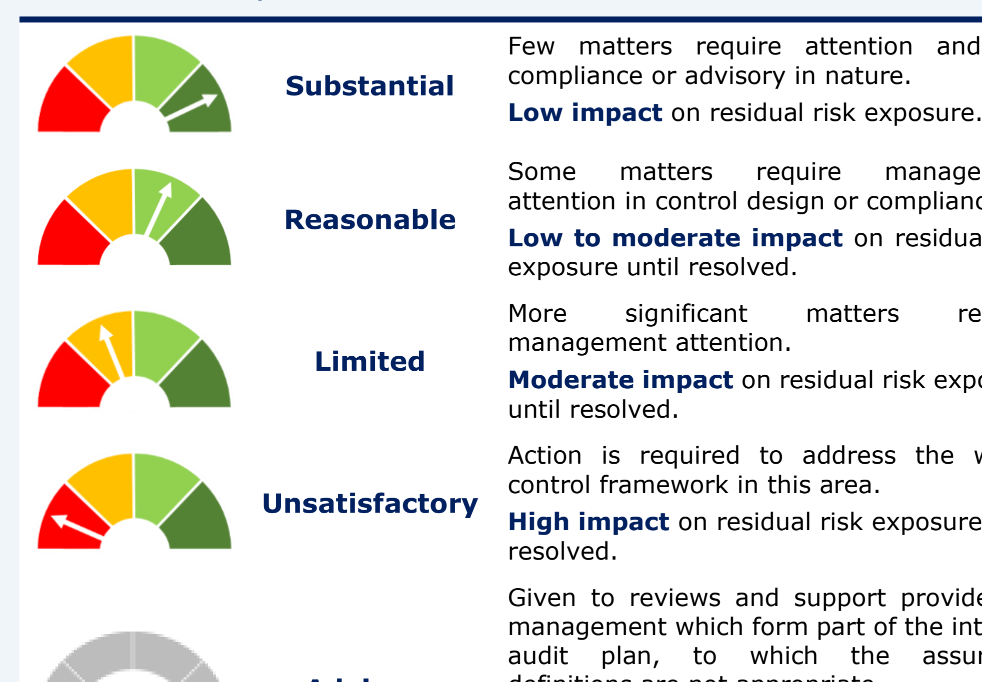
Key Findings		Risk & Impact	Agreed Management Action
4	**Post Investigation Feedback & Lessons Learned** Sample testing of 20 incidents identified 15 with no feedback form or action report, and three with no lessons learned form. Whilst lessons learned are recorded within the appropriate field on Datix, 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.	Failure to learn from incidents resulting in repeated incidents, potentially resulting in harm to staff/public, service disruption, financial loss or reputational damage.	**Agreed Action:** 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.
			Expected Evidence of Implementation: Governance group meeting papers demonstrating review / discussion / dissemination of lessons learned. Correspondence with staff (e.g. newsletters, team briefings) demonstrating shared learning. The completed HCS RTI Datix Investigation Checklist will be added to Datix to evidence closure of the process and documentation trail.
		Medium Priority	**Officer:** Regional Managers (CVUHB and SBUHB) **Target Implementation Date:** w/c 6TH July 2026
	Theme: Lessons Learnt	Control Design	
5	**Insurance Claims & Costs Associated with Vehicle Incidents** A record of vehicle insurance claims is not maintained, although this information is available from the insurer. Vehicle repairs under £1000 do not go through insurance and are paid for instead. We were unable to quantify the volume or value of these repairs as this information is not centrally recorded or monitored. During 2025, 66 claims were submitted to the insurer; six of these could not be matched to a corresponding incident report on Datix – four incidents had been recorded with incorrect vehicle registration and two required recording on Datix.	Failure to learn from incidents resulting in repeated incidents, potentially resulting in harm to staff/public, service disruption, financial loss or reputational damage.	**Agreed Action:** A central register of insurance claims and non-insurance repairs will be established and monitored, with periodic reporting to the Senior Leadership Team governance meetings. The register will record the corresponding Datix incident reference, ensuring that all incidents are reported and investigated. A fleet repair approval process has now been implemented to ensure the respective HCS Managers were aware of the costs associated with vehicle damage that was occurring within their areas of responsibility, and all approvals are tracked for auditability and trend analysis will be undertaken when sufficient data is available. A tracker capturing all insurance claims has been in place for some time however this will be reviewed to ensure it captures all the data required to offer auditable assurances to include repairs and Datix references.
			Expected Evidence of Implementation:

			Central register of insurance claims and vehicle repairs will be used to capture all data required. Governance group meeting papers demonstrating reporting/review.
		Medium Priority	**Officer:** Regional Manager (Fleet) **Target Implementation Date:** w/c 29th June 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Appendix A

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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

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Public Sector Internal Audit Standards

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

Recruitment and Retention

Final Internal Audit Report

2025/26

NHS Wales Shared Services Partnership

Substantial Assurance

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Review Reference	SSP-2526-10
Fieldwork	April - May 2026
Executive Sign Off	3 June 2026
Audit Committee	15 June 2026
Executive Lead	Gareth Hardacre, Director of People & Organisational Development and Employment Services
Audit Team	James John, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the adequacy of arrangements within NHS Wales Shared Services Partnership for recruitment and retention.

Attracting and retaining high-calibre staff is a strategic priority across NHS Wales due to increased service demand and a highly competitive market for both clinical and non-clinical professionals. Ensuring that the organisation is positioned as an employer of choice, with strong recruitment strategies and effective retention approaches is essential for service continuity and organisational resilience.

Overview

NWSSP has implemented a corporate workforce plan aligned to strategic objectives, supported by a four-pillar approach and data-driven workforce planning across divisions. Metrics demonstrate that recruitment and retention initiatives are effective, contributing to de-escalation of the corporate risk in April 2026. Exit processes and monitoring arrangements are in place, with evidence of targeted review and associated improvement actions to reduce turnover.

We have concluded **Substantial** assurance on this area. We have identified no matters for reporting in our review.

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	Relevant strategies, policies and plans are in place that clearly outline the organisations approach to attracting and retaining a high calibre, skilled workforce. There is appropriate oversight and monitoring of delivery of these.	-	**Substantial**
2	Mechanisms exist to collect and analyse data in relation to staff retention, including turnover rates and feedback from leavers, with lessons learned incorporated into retention plans and processes.	-	**Substantial**

Findings

Objective 1: Relevant strategies, policies and plans are in place that clearly outline the organisations approach to attracting and retaining a high calibre, skilled workforce. There is appropriate oversight and monitoring of delivery of these	Substantial

In 2024 NWSSP has implemented the Workforce Plan – Corporate Strategy aligned with the organisations strategic objectives and core values, and underpinned by a four pillar approach – *Attract, Retain, Develop, Engage*. Measures were agreed to track progress of the plan (Appendix 1) and reported to the Senior Leadership Group (SLG). Only one measure (minimum 5% reduction in voluntary resignation) is not achieved but does show an improving trend.

Fundamentally, all divisions were supported to develop and are operating formalised, data-led workforce plans aligned to the NHS Wales 6-Step Model. POD analysis of these plans identified recruitment and retention as one of six key cross-divisional challenges. Actions have been identified for implementation during 2026/27 and monitoring through the quarterly review process.

NWSSP engages a broad range of initiatives to attract and retain the right people in the right roles. Key examples include:

- Focus on 'employee value proposition' – the core benefits forming part of the wider employer brand – compensation, wellbeing/recognition, career pathways and environment/culture. These are communicated via the intranet and internet sites.
- Engagement with universities and colleges to promote early career opportunities.
- Tailored workforce development approaches including work placements, apprenticeships, Network 75 programme and graduate schemes to develop a talent pipeline.
- Use of social media, videos and animations (organisation and division specific) to engage potential candidates, with guidance to support candidates in their application.
- Focus on reducing time to hire through manager training and performance improvement to optimise recruitment success.
- Recent re-establishment of the Recruitment & Retention Group.

We identified good practice with evidence to demonstrate that the effectiveness of initiatives is measured. Examples include case studies to assess the impact of the employee value proposition on application volumes and recruitment success; and the impact of enhanced and consistent branding on social media click through rates.

In April 2026 risk A2 relating to the organisations ability to recruit and retain appropriately skilled people was de-escalated from the corporate risk register following sustained improvement in time to hire metrics and consistent achievement of KPIs. Risks remain on divisional risk registers where appropriate.

Objective 2: Mechanisms exist to collect and analyse data in relation to staff retention, including turnover rates and feedback from leavers, with lessons learned incorporated into retention plans and processes	Substantial

NWSSP has an Exit Protocol offering every employee who voluntarily submits their resignation from their post to provide an exit questionnaire and if requested an exit interview. Monthly reports are run to identify leavers and disseminate the survey, which is now MS forms based to improve ease of use and encourage completion.

Dashboards facilitate monitoring of staff turnover at an organisational and divisional level and leavers data is reported monthly to SLG. The three-year staff turnover cycle has seen a reduction from 12.42% to 8.87% demonstrating an improving trend, whilst recognising there is still scope for considerable improvement.

There is evidence that action is taken to investigate and address any areas of concern, with recent deep dive reviews into leavers within first year of employment, and a division experiencing high turnover. Feedback and themes identified from the survey results and deep dive reviews are used to drive improvement and inform organisational and divisional workforce plans. For example, the 'destination on leaving' field in the staff movement advice app has been refined to remove the 'unknown' option, to improve data quality.

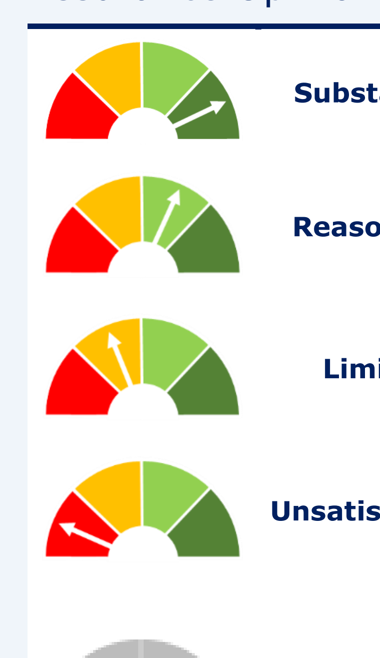
Appendix A: Workforce Plan – Corporate Strategy: Implementation Measures

Theme	Measure	Outcome	Status
Workforce Plans	All Divisions across NWSSP to have a formalised Workforce plan by the end of 2024/25 IMTP year	All Divisional plans in place by April 2025	Achieved
Attract	Reduce time to hire KPI to meet SLAs	Time to hire reduced from 75.6d (March 2024) to 41.8d (July 2025)	Achieved
Attract	Analyse divisional data for KPI compliance	Divisional data analysed to ensure time to hire KPIs met. Monitored through quarterly reviews.	Achieved
Attract	Reduce agency spend by 15% year on year	Year on year savings: Agency £884k – 77% Bank £54k – 19%	Achieved
Retain	Minimum 5% reduction in voluntary turnover	2023/24 – 8.28% 2025/26 – 5.17%	Not achieved (but improving trend)
Retain	Evidence from leavers questionnaire & Power BI data	58.2% of leavers due to voluntary resignation – down two thirds since August 2024	Achieved
Develop	Create formalised career pathways		Achieved
Develop	Managers training plans	Participation in relevant training courses including Aspiring Managers Training (44); Leading for Excellence & Innovation Programme (31); Managers Induction (56); Recruitment Training (80)	Achieved
Engage	30% workforce agile working		Superseded by JD Modernisation 2026
Engage	5% of new roles allow agility		Superseded by JD Modernisation 2026

Source: POD report to SLG January 2026

Appendix B

Assurance Opinion



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South East Wales Radiopharmacy

Final Internal Audit Report

2025/26

NHS Wales Shared Services Partnership

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Review Reference	SSP-SSU-2526-17
Fieldwork	January 2026 – April 2026
Executive Sign Off	June 2026
Audit Committee	June 2026
Executive Lead	Alison Ramsey, Director of Finance and Corporate Services
Audit Team	Huw Richards, Head of Internal Audit David Butler, Audit Manager

Executive Summary

Purpose

The audit sought to evaluate the progression of plans to deliver a South-East Wales Radiopharmacy unit in accordance with the Integrated Audit Plan approved within the business case. This is the second of two reviews within that plan – the first provided assurance in relation to project initiation and design, and this, the second, has reviewed both the outcome of the enabling works and progression of the Clean Room construction phase. At the time of the prior audit, contractual arrangements relating to the build phase remained to be finalised.

Enabling works completed in June 2025 ahead of delivery of the Clean Room.

Overview

Reasonable assurance has been determined following assessment of delivery performance against the project's key objectives and review of the governance, contractual, and internal control arrangements applied to date. This rating reflects some identified weaknesses in contractual and financial control design and operation, rather than a failure of the project to progress or remain financially viable.

The project is forecast to be delivered **within budget**, with an anticipated underspend of **£0.725m (9.7%)**. At the conclusion of audit fieldwork, forecast operational completion reflected an overall delay of circa 12 months compared to the targets determined within the approved business case. Around eight months of this delay arose during the planning stage, with later slippage extending the period during which partner Health Boards remained reliant on a single source of radiopharmacy production at the existing facility. Whilst this had the potential to delay the realisation of anticipated benefits, at the time of concluding the audit, the build had been handed over with final validation steps concluding.

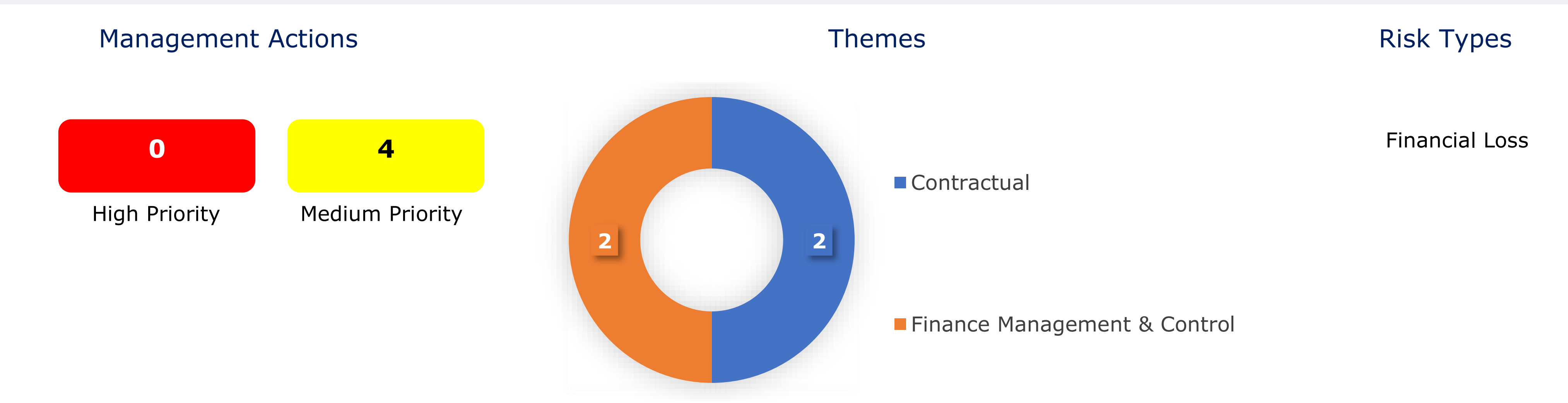
Key matters raised for management attention include the need to:

- strengthen contractual arrangements, including:
  - utilisation of a more comprehensive / standard form of construction contract to more fully safeguard client interests (including those relating to change control, performance oversight, build validation, and post completion defects liability etc); and
- recognising the extensive change control authorisation processes applied, to more fully describe these within established control documents i.e. Project Initiation Document/Project Execution Plan.

Full details of the issues identified, and the agreed management actions are set out in the **Findings & Agreed Action Plan** section.

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	Project Performance – consideration of delivery performance against the project's key delivery objectives (time, cost, and quality).		**Substantial**
2	Validation of Management Action - that previously agreed actions have been appropriately addressed by management.		**Substantial**
3	Governance - assurance that appropriate governance arrangements are maintained throughout the construction and delivery of the project.		**Reasonable**
4	Project Management – assurance that appropriate contractual controls have been applied during the construction phase, with associated monitoring and reporting of performance, payments, quality, and planning controls.	1	**Reasonable**
5	Design Change Management and Control - To review the control and reporting of any project changes, including the potential time and cost impact, and associated risk and contingency management.	2, 3	**Reasonable**
6	Equipping – assurance that equipment procurement requirements have been fully considered and agreed; tendering and quotation exercises are undertaken in accordance with NWSSP / NHS Wales procurement regulation requirements; and sufficient time has been afforded to procure the required equipment.	4	**Reasonable**



South East Wales Radiopharmacy – At a Glance

The South East Radiopharmacy project forms part of the Transforming Access to Medicines (TRAMS) Programme, overseen by the South-East Wales Project Board. Phase 1 of the programme involves the establishment of a South-East Wales Radiopharmacy unit, initially focused on supporting patient scanning. The project will relocate the existing University Hospital of Wales Radiopharmacy service to Imperial Park (IP5), Newport, improving resilience and capacity of supply across the region.

Enabling works were completed in May 2025, ahead of the commencement of the Clean Room.

Time

The approved Business Justification Case (BJC) targeted operational delivery by July 2025. At the time of audit, the forecast "go-live" date had extended to July 2026, representing an overall delay of approximately 12 months.

Table 1

Milestone	Per BJC	Contract Start Date	Actual Start Date	Contract End Date	Extensions of Time	Actual Completion	Go live	Forecast / Actual Delay
Enabling works		03/02/25	03/02/25	23/05/25	-	30/05/25		1 week
Build		21/05/25	23/06/25	11/02/26	-	31/03/26		7 weeks
Operational	**01/07/25**						**July 26**	**12 Months**

The "Go Live" forecast has extended from 1 month in the plan to 3 months post-handover and remained under assessment.

The majority of this delay (**circa eight months**) arose during the planning stage, prior to the commencement of construction (assessed at the prior audit).

More recent programme slippage reflects build-phase performance issues and the extension of the planned "go-live" period following handover.

Cost

Management have reported forecast expenditure to April 2026 as follows:

Table 2

Project summary April 2026	Approved budget £'000	Forecast project outturn £'000	Variance to Budget (fav)/adv £'000	Finance Lead Variance Commentary
Funding				
BJC application	9,168			November 2023 application
Revised funding (July 2024)	**7,460**			Following reduction in isolator requirements / costs of £1.708m arising from effective market engagement
Costs				
Enabling works	963	963	-	
Design	214	80	(134)	
Clean room (main works)	2,253	2,436*	183	
Fees	641	513	(128)	
Non-Works costs	1,099	1,292	193	
Equipment costs	731	687	(44)	
Contingency	590	25	(565)	
VAT	969	739	(230)	
Total	**7,460**	**6,735**	**(725)**	**-9.72%**

*Note – this includes £354k relating to an environmental monitoring system (EMS) transferred to the Contractor for supply and fit

Findings & Agreed Action Plan

Objective 1: Project Performance	**Substantial**

Overview / Summary of Observations

At a project audit, assurance is derived from assessment of progress against the project’s key delivery objectives of time, cost, and quality, together with consideration of whether governance, risk management, and internal controls support effective delivery.

Time

As set out in **Table 1**, forecast operational completion at the time of audit reflected an overall delay of approximately 12 months against the timelines approved in the Business Justification Case (BJC). The majority of this delay (circa eight months) arose during the planning stage and was assessed as part of the prior audit review.

Practical completion of the enabling works was achieved on 30 May 2025, one week later than the contractual end date. No delay damages were specified within that contract, and the construction-phase Contractor identified this delay as a contributory factor to subsequent programme pressure. The Clean Room was delivered approximately six weeks behind the agreed programme (circa 16%), with Contractor performance cited as a primary factor.

Forming part of this delay, the forecast “go-live” period had also extended from one month to three months post-handover and remained subject to ongoing review. While there were no material construction delays beyond those noted above, the cumulative effect of earlier planning delays and subsequent slippage has extended the period during which services continue to rely on a single source of production, with implications for service resilience and benefit realisation.

Cost

The construction contract was originally agreed at £1.644m, against an approved works budget of £2.253m. As at April 2026, forecast out-turn costs for the Clean Room were £183k over budget. However, this position includes the transfer of £354k of an environmental monitoring system (EMS) to the Contractor for supply and fit. Net of this transfer, works remain within budget.

At a total project level, as at April 2026, the project was forecast to be delivered £725k (9.72%) within its approved budget.

Quality

At the time of audit, works were progressing in accordance with approved planning permission. Specialist Clean Room Contractors were engaged, and clinicians were involved throughout the design and build phases. Technical advisers were in place to support quality assurance, including site visits and informal advice to the Contract Manager.

Formal contractual requirements governing quality assurance and defects liability have been assessed at **Objective 4: Project Management**. **No quality defects or safety concerns had been reported at the time of audit**, and works were proceeding in line with agreed technical specifications.

Conclusion
Recognising progression within budgeted costs and ongoing delivery of the project objectives (handover having been achieved at the time of concluding audit), **substantial** assurance has been determined in respect of project performance.

Objective 2: Validation of Management Actions	**Substantial**

Overview / Summary of Observations

The prior audit was published in October 2025, providing "***reasonable***" assurance with 10 "***medium***" priority actions. The follow-up position may be summarised as:

Objective	Agreed Management Actions	Implemented	Outstanding	Future	Comments
Governance	**Approvals** At the earliest opportunity formal planning permission applications will be submitted. If this is not forthcoming due to delays beyond our control we will not proceed without agreement of the Project Board, Programme Board, and Welsh Government.	-	-	1	For implementation at future programme stages
	Project Initiation Document The documentation comprising the PID will be updated for any significant changes in the project.	-	-	1	The Project Initiation Document (PID) defines controls applicable to the commencement of a project. As the project progresses through stages such as specification, procurement and construction, the parties involved and defined interactions are typically redefined at a Project Execution Plan (PEP) applicable for each stage. While noting the need for current amendments to the PID / PEP (e.g. finding 2 - variations), due to the late stage of the project, management confirmed that the next step change in management arrangements would be applied at the TRAMS project.

	Project Director For future projects all roles will clearly be defined at the Project Initiation Document (PID) stage and formal confirmation of the duties accepted noted and integrated into the Project Board terms of reference.	-	1	-	While the named Project Director had been updated, no further changes had been made to the PID. Key roles such as Project Director continued to lack sufficient definition (as narrated at the prior audit).
	Capital Procedures The Capital Procedure has been approved and adopted since the audit commenced. The Capital Procedure will be reviewed and updated on an annual basis, and we will be cognisant of the audit observations in the interim.	-	-	1	Target implementation Q2 2026
Contractual arrangements	**Design Sign-off** In future, design specifications on other projects will be reviewed and approved by the relevant Project Board and the action will be added to the Capital Procedure.	-	-	1	Target implementation Q2 2026
	Parent Company Guarantee A Parent Company Guarantee from the ultimate parent in the group has been sought and the Capital Procedure will be updated.	1	-	-	At the initial audit, a Parent Company Guarantee had been obtained, but not from the ultimate holding company. A Parent Company Guarantee from the ultimate holding company has now been obtained, together with appropriate vetting. Management have added the requirement for refresh of financial vetting at each project stage for on-going financial assurance. The Contractor had re-registered and changed name since the original contract. Together with the potential for re-structure, the need for on-going vigilance is highlighted.
	Delay Damages For future projects discussion will take place with service users and cost advisor via the Project Board to ascertain whether delay damages should be included and if so the basis of the calculation.	-	-	–	Superseded by **finding 3**
Financial monitoring	**Costed Risk Register**	1	-	-	This was reported to the November Project Board

	We will review and update the register with costed risks and report it to Project Board.				
	Appropriate Budget Monitoring	1	-	-	This was confirmed as actioned prior to publication of the prior audit.
	Project Progress Return Welsh Government colleagues will be asked at the next Capital Monitoring Meeting whether these reports are required in addition to existing reporting.	1	-	-	It was confirmed with Welsh Government in December 2025 that a Project Progress Return (additional to existing Radiopharmacy reporting) would not be required. (In this context the presence is noted of the Deputy Director of NHS Capital Estates & Facilities at the Programme Board to which project reporting is provided).
	Total	**4**	**1**	**4**	

Noting actions to date substantial assurance has been determined noting that the majority of agreed actions are due for application at the next phase of the programme.

Objective 3: Governance	**Reasonable**

Overview / Summary of Observations

A Project Board was in place with approved terms of reference, providing oversight of delivery, risks, and key decisions. The business case was approved by both the Shared Services Partnership Committee and the Velindre University NHS Trust Board, with Welsh Government capital funding approvals issued to the NWSSP Managing Director.

Key roles, including the Senior Responsible Officer, Programme Director / Project Executive, and Project Manager, were established, with regular attendance at Project Board meetings. Finance representation and Director of Pharmacy leads from Health Boards and Trust across South-East Wales were in place, ensuring both financial and clinical stakeholder oversight. The project was also supported by internal project management expertise. Stakeholder interests were therefore seen to be appropriately represented, and the Project Board included an appropriate range of expertise to scrutinise and oversee the project.

The Project Board received regular finance, adviser, and programme reports, with agendas and minutes evidencing decision-making and escalation. Declarations of interest were routinely recorded, and specialist supporting groups operated alongside the Board.

Key issues were reported to the Programme Board with additional approval (where relevant) by both the NWSSP Managing Director and Chair. Briefing papers were also provided to the Velindre University NHS Trust Chief Executive (where required).

One previously agreed governance action relating to formal definition of the Project Director role remained outstanding and is considered at **Objective 2**). Previously agreed actions have been appraised at **Objective 1 - Validation of Management Actions**.

Issues associated with the operation of approvals have also been raised within the **Design Change Management and Control** section.

Accordingly, **reasonable assurance** is provided in relation to governance.

Objective 4: Project Management	**Reasonable**

Overview / Summary of Observations

The audit sought to ensure whether appropriate project management and contractual controls were applied during the construction phase, including oversight of performance, cost, quality, and contractual compliance.

The Project Board received regular programme and financial reporting, supported by input from the Project Manager, Contract Administrator, and technical advisers. Project risks were monitored, and valuations and payments were overseen through established processes. These arrangements provided dynamic delivery oversight. Onward reporting and approval of key issues was also provided to the Programme Board, Shared Services Partnership Committee, and the Velindre NHS Trust Board.

While a standard NHS procurement contract was applied to the Clean Room construction phase, this lacked some protections which would typically feature within standard form construction contracts, including defined performance controls, mechanisms for managing changes to time and cost, inflation, delay provisions, and defects liability. At the current phase, project break clauses were being utilised to ensure appropriate co-operation, and though one instance of performance had been raised, the project was being successfully delivered. Similar considerations applied to adviser contracts.

Delivery within budget has been assessed at **Project Performance**. While noting the potential to improve contractual controls, noting effective operational management and oversight **reasonable** assurance was determined in relation to project management.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Contractual Control (Build Contract)** 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. However, typical contractual controls within construction contracts include: • Programme control (notably agreed start and end dates, a contractually agreed / revised programme and delay damages); • defects liability; • costed programme activities; • priced risks; • methodologies for agreeing changes to time and cost (including information / costing response times); • inflationary uplift methodology; and • performance monitoring.	The absence of comprehensive, construction contractual protections increase the risk that time, cost, and quality issues are not managed consistently or enforced effectively, reducing the client's ability to protect its interests throughout delivery.	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. Additional comment: 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.

Potential issues of the current form of contact could include matters such as:

- impaired post contract defects protection. Standing Orders provide for contracts to be executed as a deed or sealed (a deed being necessary to ensure 12 years defects liability) (Typically defects identified up to a year following completion are rectified ahead of final payment. Those subsequent to final payment are subject to separate remedies);
- ability to enforce a contractual programme - whilst a programme was in place, this was not a contractual inclusion and agreed start and end dates were not referenced within the contract. Similarly, mechanisms for updates, and management of delay were not in place; and
- an agreed inflationary mechanism.

It is recognised that the break clauses formed a basic tool to ensure effective performance and co-operation of the main Contractor, together with quality monitoring by specialist advisers. However, such incentives would not apply at the final (TRAMS) phase and do not negate the need for effective contractual controls.

Similar considerations apply to adviser contracts, where both requirements and contract operation could be more precisely specified e.g. for a validation consultancy contract requirements were specified as:

Support for Build Phase of Suite "R" including support for FAT & SAT
Support for Validation Phase of Suite "R" including IQ and OQ
Support for PQ of Suite "R"

Rather than a more quantified / time related provision of services. Similarly for another adviser requiring "visits" and "reports".

A more detailed form of contract would also facilitate progress monitoring e.g.

<u>Progress monitoring</u>

The Contract Administrator made professional assessments of works completed to inform progress monitoring (as supplemented by specialist advisor visits, assessing technical aspects of delivery). However, additional contractual controls (as applied at other forms of contract) may variously include a priced activity schedule or time-phased cost plan (providing the ability to

	objectively assess progress against resource deployment and expected cash flow). While informed by Contractor assurances of progress against programme, emerging performance issues were identified late. This reduced the effectiveness of early challenge and intervention e.g. the Contract Administrator stated in the November 2025 progress report that "*we identified on a number of occasions in the weekly progress meetings concern as to the lack of site personnel on site and works progress*" but that "*at each progress meeting the Contractor has confirmed that no extension of time would be required.*" Subsequently, the programme has been re-issued to include a four-week delay. The audit was advised that as a result the Clean Room contract lead has been replaced. At future / more complex phases the project may therefore benefit from additional contractual performance controls as provided for within modern construction contracts. For any additional contractual controls (applied to future stages), the Project Initiation Document should also be amended to reflect associated internal controls e.g. identified staff communication mechanisms and meetings for escalation of issues.		**Expected Evidence of Implementation:** South West and North Wales Hubs will have appropriate building contracts.
		Medium Priority	**Officer:** Programme Manager **Date:** 30th June 2027 / on letting of contracts
	Theme: Contractual	Control Design	

Objective 5: Design Change Management and Control — Reasonable

Overview / Summary of Observations

The audit sought to ensure the effectiveness of arrangements for identifying, approving, and controlling changes to design, scope, time, and cost during the construction phase.

The status of proposed changes and mitigations was monitored in meetings with the Contractor, client, and Contract Administrator.

Changes to the build were discussed and monitored through meetings involving the Contractor, Project Manager, and Contract Administrator. Variations to the contract price were approved by the Contract Administrator through Variation Orders, and overall expenditure was monitored against available Purchase Order limits.

However, the processes operated were not fully described within project controls. Also, the distinction between contractor-initiated changes and client-initiated changes was not clearly defined, limiting visibility over the drivers of cost and programme movement. Additionally, the contract did not clearly specify information requirements for the provision of change costings, reducing the effectiveness of challenge and approval.

While noting the need to enhance and more fully defined processes, noting the range of monitoring, reporting and authorisation controls, **reasonable** assurance is determined in relation to design change management and control.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Contractual approval of variations** Regular reporting and extensive authorisation controls were evidenced 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. However, the processes operated were not fully described within project controls. 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). 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). Associated Variation Orders were agreed between the Contract Administrator and the Contractor as follows:	Contractual commitments may be incurred ahead of internal scrutiny and approvals.	The capital financial control procedure will be revised to detail requirements for the processing of variation orders and change request forms.

VO	VO issued date	£	VO issued in advance of CCN (Days)
16	01/05/2025	29,547	**92**
17	16/04/2025	15,713	**107**
18a	30/05/2025	4,494	**63**
21	15/07/2025	17,901	**17**
	Total CNN 3	**67,655**	

These variation orders were listed on both the Contact Change Request and Contract Change Note and retrospectively approved in batches.

Management have indicated that there was advance awareness of both Variation Orders and Change Control Requests to all relevant parties, and subsequent notifications to the Finance Lead were evidenced. The Contract Administrator also reported Variation Orders at Cost Reports. However, whilst recognising the same, there were evident delays in the application of the formal approval process. This may be a consequence of the batching of variations.

It was noted that the defined project change control processes did not include description of the operation of either Variation Orders or Change Request Notices. Such description could for instance define any delegation to the Contract Administrator.

There was a need therefore to align the intended and actual operation of change control.

Expected Evidence of Implementation:

Capital financial control procedure to be revised.

Medium Priority

Officer: Programme Finance Lead

Date: 30th September 2026

Theme: Contractual

Control Design

3

Contractor versus client change

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.

Failure to clearly distinguish between contractor and client-initiated changes reduces transparency, weakening Project Board oversight, and limits the ability to assess root causes of cost and time movement or inform

Agreed Management Action:

Review and amend report templates to make contractor versus client changes explicitly clear for future projects.

	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.	future project planning and risk allowances at future project stages.	**Expected Evidence of Implementation:** Revised change request forms and associated reporting delineating between client and contractor change.
		Medium Priority	**Officer:** Programme Finance Lead **Date:** 30th September 2026
	Theme: Finance Management & Control	Control Design	

Objective 6: Equipping — Reasonable

Overview / Summary of Observations

The audit sought to ensure that equipment procurement arrangements were appropriately planned, approved, and undertaken in compliance with procurement regulations and Standing Financial Instructions (SFIs), and whether sufficient monitoring was in place to support delivery.

Overall, equipment requirements were identified and monitored, with particular focus on higher-value items such as isolators. (Equipment comprised of isolators at circa £0.242m and other items budgeted at circa £0.488m (excl. VAT). A saving of £19.8k was projected against this sum - as per ***Table 2***).

Competitive tenders for isolators were seen to be appropriately assessed, scrutinised and approved, to secure best value. A sample of eight further high value items of equipment was undertaken to assure best value procurement in accordance with Standing Financial Instructions (being 43% of remaining items).

Monitoring of the equipment budget was undertaken by the Finance lead, though at the time of audit £64,675 (net of VAT), remained to be detailed, limiting the completeness of reporting at a relatively advanced stage of the project.

Noting the general application of appropriate procurement practices together with management and monitoring evidenced, **reasonable assurance** has been determined in relation to equipping.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Equipment list** 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. At the time of audit, the equipment monitoring spreadsheet showed (net of VAT):	Project controls are not fully utilised impacting project delivery.	At future programme stages we will look to fully allocate and identify any equipment contingency by the latter stages of the project.

	As at fieldwork	**As at publication**
Item	**£'000's**	**£'000's**
Isolators	242	242
Other	403	403
Not defined	65	41

Surplus	20	44
Budget	730	730

The sum of £64,675 was stated to be “*additional items pending quotes / prices*” without further breakdown.

Clear identification and confirmation of all remaining equipment requirements is necessary to support effective financial monitoring, delivery planning, and assurance that procurement activity is complete and appropriately controlled.

Further to audit fieldwork and prior to publication of this report, it was confirmed that £44k represented underspent budget (an increase to the surplus shown above) (see **At a Glance** section). This would adjust the not-defined sum (above) to £41k.

Expected Evidence of Implementation:

Project monitoring and reporting at future programme stages will fully allocate and identify any equipment contingency by the latter stages of the project.

Medium Priority

Officer: Programme Finance Lead

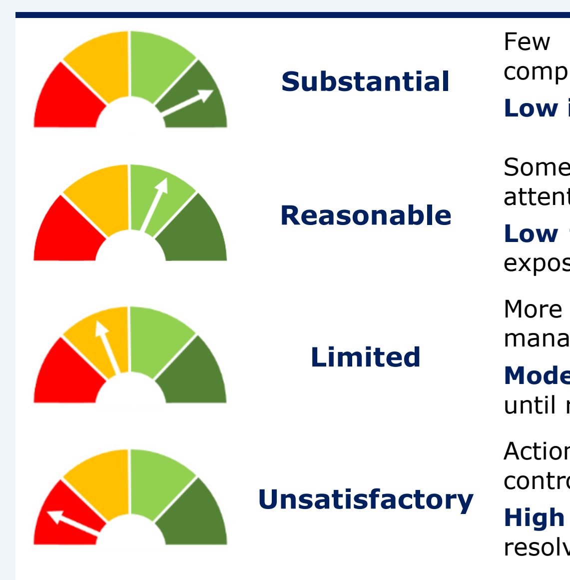
Date: 30th September 2026

Theme: Finance Management & Control

Control Operation

Appendix A

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of 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.

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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

Budget Setting

Final Internal Audit Report

2025/26

NHS Wales Shared Services Partnership

Substantial Assurance

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Review Reference	SSP-2526-09
Fieldwork	April – May 2026
Executive Sign Off	4 June 2026
Audit Committee	15 June 2026
Executive Lead	Alison Ramsey, Director of Finance & Corporate Services
Audit Team	James Johns, Head of Internal Audit Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

Under the NHS Finances (Wales) Act 2014, NHS organisations have a statutory duty to prepare a three-year Integrated Medium-Term Plan (IMTP), which is updated annually, that sets out how they will comply with their financial break-even duties over a rolling three-year period. The Well-being of Future Generations (Wales) Act 2015 set in law the need to consider the long-term strategic approach to deliver a better future, including within financial planning and budget setting. The NWSSP IMTP for 2025–2028 (approved by the Shared Services Partnership Committee in February 2025) represents a balanced position for all three years, although this is contingent on achievement of savings targets and confirmation of funding streams.

The objective of this audit was to review how NWSSP allocates resources to meet its agreed budget.

Overview

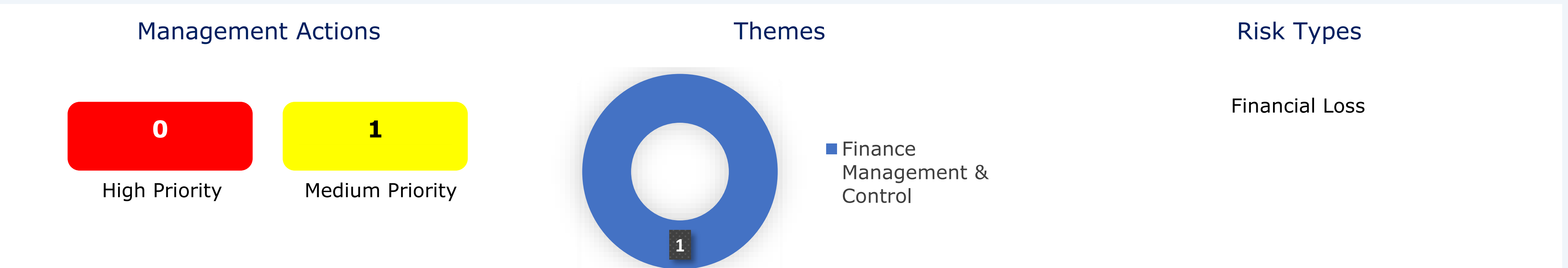
The audit highlighted that the budget-setting process is well-defined, consistently applied, and aligned with Welsh Government requirements through the Integrated Medium-Term Plan (IMTP). Accountability conditions are fully embedded across governance, quality, workforce, equality, and financial planning. Engagement is strong, involving stakeholders, finance teams, and budget holders, supported by regular meetings and transparent communication. Budgets are largely incremental, based on documented assumptions, prior-year data, and prudent planning, with risks, contingencies, and reserves appropriately identified and managed. Governance and monitoring arrangements are robust, including regular reporting, performance reviews, and committee oversight. Budget holders receive training and support, with clear delegation of responsibilities via formal letters. Systems such as Qlik sense enhance budget monitoring. Overall, budgets are soundly constructed, approved, and aligned to strategic priorities, with one medium priority issue - incomplete documentation tracking [Objective 5, Finding 1].

We have concluded **Substantial** assurance on this area.

Scope & Assurance Summary

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

	Objectives	Related Findings	Assurance
1	NWSSP has an appropriate financial planning approach to ensure that budgets are aligned to key organisational priorities, available resources and Welsh Government requirements.	-	**Substantial**
2	There is clear and robust challenge of the financial plan, its assumptions, and associated risks by senior management, the Shared Services Partnership Committee and Welsh Government.	-	**Substantial**
3	Budget holders are actively engaged at an early stage and supported throughout the budget setting process, and NWSSP has sufficient internal resources, skills, and systems to enable effective budget planning.	-	**Substantial**
4	Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up-to-date policies and procedures.	-	**Substantial**
5	Effective processes are in place within directorates in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.	1	**Reasonable**


Management Actions
0
High Priority
1
Medium Priority
Themes
1
Finance Management & Control
Risk Types
Financial Loss

Findings & Agreed Action Plan

Objective 1: NWSSP has an appropriate financial planning approach to ensure that budgets are aligned to key organisational priorities, available resources and Welsh Government requirements.	**Substantial**

The budget-setting process is robust, consistently applied, and aligned with Welsh Government requirements, with accountability conditions fully embedded within the IMTP and the Finance department. The plan integrates governance, quality, workforce, equality, risk, and financial planning, reflecting national standards. Key priorities—including well-being, quality standards, inclusivity, workforce delivery, financial sustainability, and Ministerial alignment—are clearly taken account of by the Finance team when building each budget. Strong governance and monitoring arrangements, including defined KPIs and regular reporting, ensure accountability, oversight, and effective delivery.

Objective 2: There is clear and robust challenge of the financial plan, its assumptions, and associated risks by senior management, the Shared Services Partnership Committee and Welsh Government.	**Substantial**

The SSPC oversaw the development and approval of the IMTP, aligned with Welsh Government priorities and shaped by strong stakeholder engagement. Robust governance and monitoring arrangements support ongoing oversight and reporting. Budgets are informed by reviewed assumptions and finance engagement, though formal documentation is limited, there is evidence of assumptions and challenge in narrative sections of the spreadsheets used to build the budgets. Risk management is embedded through horizon scanning, scenario planning, and contingency reserves, ensuring key financial risks are identified, monitored, and appropriately managed.

Objective 3: Budget holders are actively engaged at an early stage and supported throughout the budget setting process, and NWSSP has sufficient internal resources, skills, and systems to enable effective budget planning.	**Substantial**

Budget setting is supported by comprehensive spreadsheet models feeding into the IMTP. Qlik sense provides accessible, detailed financial information to trained budget holders. While systems and finance support are strong, version control of spreadsheets are informal and reliant on individuals saving a new copy in a current folder, however reconciliation totals in each sheet make it clear if an out of date copy is being used. Budget holders receive appropriate training and ongoing support. Engagement with finance is continuous and collaborative, with clear timelines and processes ensuring effective planning, accountability, and informed budget management.

Objective 4: Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up-to-date policies and procedures.	**Substantial**

Budget setting is a formally governed process within the NWSSP framework, aligned to Standing Financial Instructions and embedded in the annual financial planning cycle. Delegations are reviewed and reapproved annually, with SSPC oversight of the IMTP and financial plans. Standardised budget holder letters confirm accountability, authority, and training requirements, ensuring responsibilities are clearly defined, communicated, and understood across all directorates.

Objective 5: Effective processes are in place within directorates in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.

Reasonable

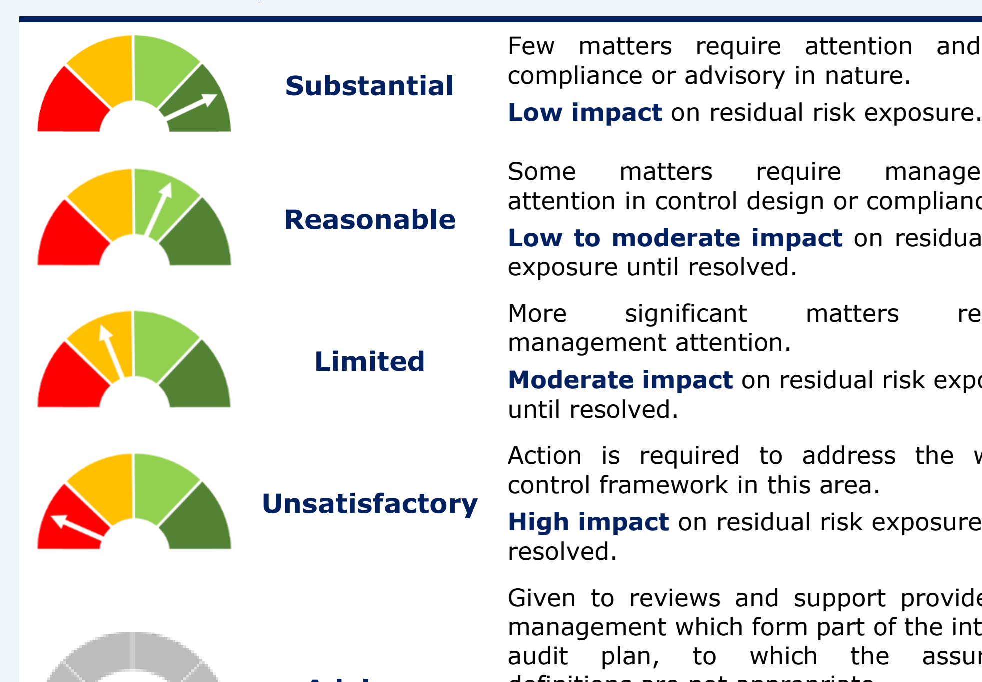
Budget setting is primarily incremental, with zero-based approaches applied where new or significantly changed services arise. Annual identification of savings and cost pressures informs IMTP submissions, with budgets based on robust, justifiable assumptions and were aligned to a £791m plan in 25/26. Controls and reconciliation processes are effective, with budgets accurately reflected in the ledgers.

While governance is generally strong, some control weaknesses exist, including incomplete tracking of budget holder acceptance [Key finding 1]. Budget rollout is supported by structured engagement and clear communication. Overall, budget setting is well-controlled, evidence-based, and operationally effective.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Budget letter tracking** 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. On reconciliation of budget holder letters returned to the IMTP it was found that one of the returned letters covering five directorates and £322k worth of budget spend related to a previous year.	Inaccurate information as to status of whether budget letters are sent, signed or returned	**Agreed Action:** 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. **Expected Evidence of Implementation:** Template updated with new fields to be used to monitor issue and return of budget holder letters from 2026/27
		Medium Priority	**Officer:** Head of Financial Resources, Systems & Planning **Target Implementation Date:** 30 June 2026
	Theme: Finance Management & Control	Control Operation	

Appendix A

Assurance Opinion



Opinion	Definition
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Head of Internal Audit Final Opinion & Annual Report 2025/26

NHS Wales Shared Services Partnership

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3. **Other work relevant to NWSSP 11**
4. **Delivery of the Internal Audit Plan 12**
5. **Risk based audit assignments 13**
6. **Acknowledgement 17**

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Report status:	Final
Draft report issued:	4 June 2026
Final report issued:	8 June 2006
Author:	James Johns
Audit Committee:	15 June 2026

1. Executive Summary

1.1 Purpose of this Report

The Managing Director of NHS Wales Shared Services Partnership (NWSSP) is accountable to the Shared Services Partnership Committee (SSPC) for maintaining a sound system of internal control that supports the achievement of NWSSP's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This Head of Internal Audit Opinion is based upon the work delivered in accordance with the risk based Internal Audit Plan for 2025/26 year, which was presented to and approved by the Audit Committee (Velindre University NHS Trust Audit Committee for the NHS Wales Shared Services Partnership) in April 2025. However, due to uncertainty over the ongoing Governance review the Charter & Mandate received retrospective approval in April 2026. The audit work for 2025/26 was delivered in line with requirements set out in the Mandate and Charter. The 2026/27 Internal Audit Plan and Charter & Mandate was also approved at the April 2026 Audit Committee.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Global Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2025/26

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Managing Director as Accountable Officer and the Shared Services Partnership Committee which underpin NWSSP's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore NWSSP will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Governance Statement. The overall opinion for 2025/26 is:

Reasonable assurance		The SSPC 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. Low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee. In addition, regular audit progress reports have been submitted to the Audit Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Global Internal Audit Standards.

The Internal Audit Plan for 2025/26 year, was presented to the Audit Committee in April 2025 with the work plan receiving approval. However, due to uncertainty over the ongoing

Governance review the Charter & Mandate only received retrospective approval in April 2026. Changes to the plan have been made during the year and these changes have been reported to the Audit Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at DHCW, that support the overall opinion for NWSSP and NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we 'Fully Conform', and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards. We can state that our service 'conforms to the IIA's professional standards and to GIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on strategic and operational risk areas, along with key national systems & services; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the SSPC that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited or Unsatisfactory Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2025/26

Substantial Assurance	• Payroll Services • Primary Care Services - Ophthalmic • Targeted Estates Funding • NWSSP Recruitment and Retention • Budget Setting
Reasonable Assurance	• Accounts Payable • Singler Lead Employer • Risk Management • Digital Strategy • TRAMS Digital • Radiopharmacy (1)

	• Procurement (Single Tender actions and Declaration of Interests) • Health Courier Services Vehicle Management • Radiopharmacy (2)
Limited Assurance	• Cyber Security Governance Arrangements
Unsatisfactory	n/a
Advisory/Non-Opinion	n/a

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work.

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

As noted above, the Managing Director of NHS Wales Shared Services Partnership is accountable to the Shared Services Partnership Committee (SSPC) for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the SSPC, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The NWSSP's risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the Global Internal Audit Standards (GIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the NWSSP. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the SSPC considers but is not intended to provide a comprehensive view.

The Managing Director, on behalf of the SSPC, and through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the SSPC which underpin their own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist NWSSP in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the SSPC in reviewing effectiveness and supporting our drive for continuous improvement.

This Head of Internal Audit Opinion is based upon the work delivered in accordance with the risk based Internal Audit Plan for 2025/26 year, which was presented to and approved by the Audit Committee (Velindre University NHS Trust Audit Committee for the NHS Wales Shared Services Partnership) in April 2025. However, due to uncertainty over the ongoing Governance review the Charter & Mandate only received retrospective approval in April 2026.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2025/26 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of GIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

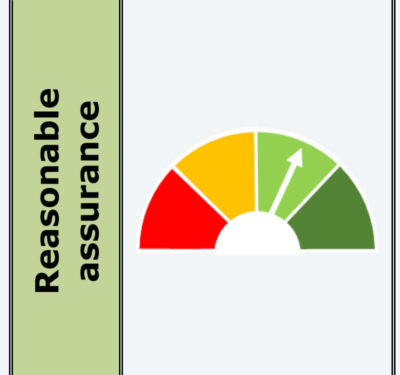
The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the SSPC and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

Scope of opinion

This Head of Internal Audit Opinion is based upon the work delivered in accordance with the risk based Internal Audit Plan for 2025/26 year, which was presented to and approved by the Audit Committee (Velindre University NHS Trust Audit Committee for the NHS Wales Shared Services Partnership) in April 2025. However, due to uncertainty over the ongoing Governance review the Charter & Mandate only received retrospective approval in April 2026.

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable assurance		The Shared Service 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. Low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to any Unsatisfactory and Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there was one audit in 2025/26) as well as addressing implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2025/26, and reported to the Audit Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially

complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.

- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the organisation has arrived at its declaration in respect of the self-assessment for the leadership standard.

  Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).

- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; attendance at meetings; review of key documents including Partnership Committee agendas and papers; meetings with Executive Directors, the Assistant Director Corporate Governance, senior managers and the Audit Committee; the results of a*d hoc* work and support provided; liaison with other assurance providers and Inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the NHS Wales Shares Services Partnership.

In reaching this opinion we have identified some reviews during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, five was allocated Substantial Assurance, nine were allocated Reasonable Assurance, one was allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the audit findings by National System / Service Audits and NWSSP specific audits, are show below.

NATIONAL AUDITS

The assurance ratings from the national system and services audits are a key component of the overall NWSSP opinion.

The audit of **Primary Care Services Contractor Payments (Ophthalmic)** concluded Substantial assurance. Sample testing confirmed that applications to join the ophthalmic performers list had been promptly and accurately processed with the requisite checks completed, and GOS claim forms had been accurately processed and reimbursed. One matter requiring management attention was highlighted relating to the requirement for new UK residents to provide an overseas criminal record check is not included on the application checklist.

Payroll Services – The audit was given a Substantial Assurance rating. Thes audit assessed the internal controls in place for core Payroll systems and processes whilst also evaluating additional specific risk areas not regularly reviewed. The controls in place for the administration of Payroll Services are designed and operating effectively and this is reflected in the continued high levels of payroll accuracy reported in KPIs (over 99%) during 2025-26, whilst the implementation of the Staff Movement Advice (SMA) platform across all NHS Wales organisations is due to be completed during 2026. This is evident in our sample testing of new starters, leavers and changes that confirmed all were processed in an accurate and timely manner. There is one matter requiring management attention relating to term time working.

The audit of **Accounts Payable** concluded with reasonable assurance. Our testing confirmed accuracy of supplier masterfile amendments and invoice processing. Some of the actions from the 2024/25 review were still ongoing at the time of audit fieldwork with target dates for implementation not yet reached. We have identified three findings requiring management action relating to: - approval arrangements for data loads, misapplication of 'in dispute' status and duplicate payments.

The audit of **Single Lead Employer** concluded with reasonable assurance. The matter requiring management attention related to gaps in evidence to demonstrate that sickness absence management is consistently managed in line with the All Wales Managing Attendance at Work policy

The audit of **Single Tender action and Declaration of Interests within Procurement** concluded with Reasonable Assurance. The audit highlighted that policies and procedures are aligned to regulatory requirements although there is opportunity to better define the processes, controls and documentation requirements specifically in relation to STAs. Sample testing identified instances where approval had not been obtained in line with SFIs and evidence was not available to demonstrate full compliance with key regulatory and policy requirements in relation to both STAs and DOIs. A Procurement Toolkit was developed in early 2025 to ensure that procurement activities are carried out efficiently, transparently and in compliance with policies and regulations. The toolkit is well designed, but sample testing found that it isn't widely utilised or effective in ensuring compliance with regulatory requirements. Consistent and effective embedding of the toolkit across procurement activity is a critical enabler in addressing the compliance issues identified throughout this review.

The audit of **Health Courier Services - Vehicle Management** concluded with Reasonable Assurance**.** Weaknesses were identified in the governance and oversight of vehicle management, with the absence for formal policies and procedures for fleet management and no single reliable mechanism to provide oversight and assurance in relation to vehicle compliance. Our testing found that vehicles are compliant with servicing, maintenance, MOT and tax requirements, although supporting evidence to demonstrate this wasn't always readily accessible particularly for leased vehicles. Vehicle incidents are reported, investigated and closed promptly. However, there is limited evidence of feedback to relevant parties and the sharing of learning to prevent recurrence. There was limited oversight of insurance claims and the volume/value of vehicle repairs.

NWSSP AUDITS

The audit of **Risk Management** concluded with Reasonable Assurance. NWSSP has an established risk management framework including a Risk Management Protocol and Risk Appetite Statement to complement the Velindre University NHS Trust risk management framework as the hosting organisation. The matters requiring management attention

included: Instances of incomplete or unclear risk narratives, inaccurate scoring, risks appear mitigated but remain open, and duplicate entries were identified a risk register. Instances where risks on the corporate register had met the tolerance target score but remained as a 'risk for action'. The steps and processes involved in dealing with emerging risks and risks for monitoring are not documented in the Risk Management Protocol.

The audit of the **Digital Strategy** concluded with Reasonable Assurance. The Digital Strategy sets out the intended direction for digital as an enabler of the wider organisational strategy. It defines a Target Operating Model and Strategic Digital Aims aligned to the corporate Strategy Map (People, Services and Value). Delivery is structured through the Integrated Medium Term Plan (IMTP) framework and supported by established programme management and governance arrangements with workstreams progressing appropriately. The matters requiring management attention included: Developing a consolidated portfolio-level oversight of Digital Strategy delivery and risks to the delivery of the Digital Strategy, developing a single document showing the full delivery roadmap and developing an integrated roadmap resource document showing the total resource demand for delivery of the Digital Strategy.

Cyber Security Governance Arrangements. Limited assurance was assigned for this audit. in this area. While we acknowledge that work has been completed and continues to progress to strengthen the organisation's cyber security posture, there remain weaknesses in risk management and governance controls that may limit the organisation's ability to manage cyber security effectively.

The **Budget Setting** audit concluded with Substantial Assurance with sound arrangements identified and only one minor issue raised

The **NWSSP Recruitment and Retention** audit concluded with Substantial Assurance

The audit of **Targeted Estates Funding** concluded with Substantial Assurance**.** The opinion reflects the notable improvements made since the previous EFAB review. The improvements demonstrate a strong commitment to transparency, consistency, and robust governance across the TEF.

The first audit of the **Radiopharmacy** project concluded with Reasonable following the assessment of the key delivery objectives and the governance, contractual and internal control arrangements applied to date. While a number of control issues have been raised, none were materially impacting the current phase. A range of best practice was also evidenced in project management of the project, notably detailed consideration of the market strategy, securing substantial market savings for the project.

The second audit of the **Radiopharmacy** project concluded with Reasonable assurance following assessment of delivery performance against the project's key objectives and review of the governance, contractual, and internal control arrangements applied to date.

The audit of the **TRAMS Digital** concluded with Reasonable Assurance. The matters requiring management attention included: Ensuring the wording used for future procurement exercises does not exclude all options for a modern digital system,

2.5 Approach to Follow Up of Recommendations

As part of our Follow-up of Previous Recommendations audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on other high priority findings in reports and also a sample of

recommendations made in prior year audits of the All Wales Transactional Systems where appropriate.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the GIAS) and the level of overall assurance that we can give.

As part of the governance arrangements within NWSSP an audit recommendation tracker was in operation during 2025/26. This is monitored and reported to Audit Committee on a regular basis, providing the ongoing position of recommendations implemented and the level of recommendations still to be actioned, with reporting highlighting a high percentage of recommendations implemented. In line with the Global Internal Audit Standards, we have undertaken follow-up work to verify the implementation of a sample of recommendations and agreed actions arising from internal audits conducted in 2024/25 and 2025/26. Of the fifteen high and medium priority recommendations reviewed, twelve have been confirmed as fully implemented, with a further two assessed as partially implemented and in progress.

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Audit Committee, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to NWSSP and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with NWSSP, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2025/26 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the NWSSP's Annual Report and accordingly will be completed and reported to management and the Audit Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2025/26.

2.9 Statement of Conformance

The Welsh Government determined that the Global Internal Audit Standards (GIAS) would apply across the NHS in Wales from April 2025.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with GIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023 stated who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at NWSSP in conformance with the Global Internal Audit Standards for 2025/26.

Our conformance statement for 2025/26 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2025/26 which will be reported formally in the Summer of 2026; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2025/26 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on NWSSP's audit programme for 2025/26.

The Head of Internal Audit has unfettered access to the Managing Director, Chair of the Audit Committee and Chair of the Shared Services Partnership Committee.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the SSPC need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the SSPC's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to NWSSP

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- Digital Health & Care Wales;
- Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to NWSSP. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Financial Sustainability	Substantial	To review the financial management arrangements in place to ensure the ongoing sustainability of services and project delivery, with a particular focus on sustainable funding requirements for projects (e.g. DPIF, WASPI).
Programme Management	Reasonable	To establish the effectiveness of the portfolio management model used by DHCW and the controls that are in place to ensure it operates across the range of active projects.
Mission One – National Data Resource	Reasonable	To provide assurance over the National Data Resource (NDR) Platform programme of work, including progress towards implementing local datastores, and reference, demographics and medicines data.

Audit	Opinion	Outline scope
Mission One – Cloud Services	Substantial	To provide assurance over the programme of work to move live services from datacentres into the cloud.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme and are summarised in the DHCW Head of Internal Audit Opinion and Annual Report. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

While these audits do not form part of the annual plan for NWSSP, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2025/26 operational audit plan.

The audit plan approved by the Committee in April 2025 contained seventeen planned reviews. Changes have been made to the plan with one audit deferred. 15 audits have been delivered with one at work in progress stage. All these changes have been reported to, and approved by, the Audit Committee.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across NWSSP. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	April 2025	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2025/26	G	*93.75%*	100%	v>20%	10%<v<20 %	v<10%

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	85%	v>20%	10%<v<20 %	v<10%
Report turnaround: time taken for management response to discussion & draft report [15 working days]	A	73%	85%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	85%	v>20%	10%<v<20 %	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 15 audit reviews were reported during the 2025/26 year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

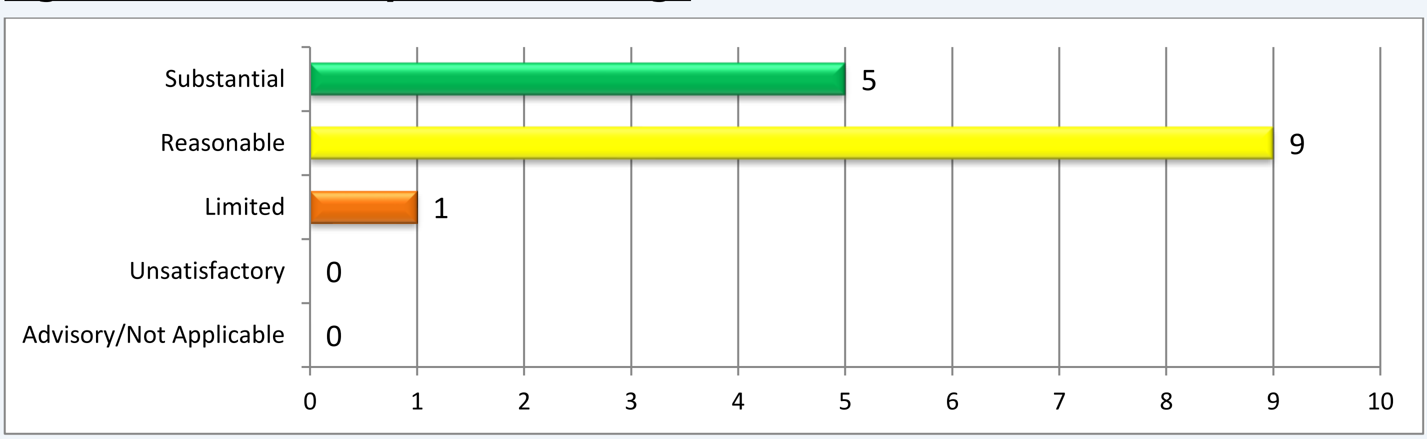


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)

In the following review areas, the SSPC can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Payroll Services	This audit will evaluate the design and operation of the systems and controls in place within payroll services.
Primary Care Services	The purpose of this review is to provide assurance that PCS is maintaining a robust system to facilitate timely and accurate payments to primary care Ophthalmic contractors.
Targeted Estates Funding	The overall objective of this audit is to evaluate processes in place to manage the prioritisation and allocation of the Targeted Estate Fund.
NWSSP Recruitment & Retention	To review the adequacy of arrangements within NHS Wales Shared Services Partnership for recruitment and retention
Budget Setting	The objective of this audit was to review how NWSSP allocates resources to meet its agreed budget.

5.3 Reasonable Assurance (Light Green)

In the following review areas, the SSPC can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either

control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Risk Management	The purpose of this audit was to review the adequacy of the NHS Wales Shared Services Partnership (NWSSP) risk management arrangements including ongoing developments.
Digital Strategy	To provide assurance over the implementation of the Digital Strategy.
Single Lead Employer	The purpose of this review is to assess compliance with a range of policies and procedures within the service. The scope of the review is limited to the remit of the Single Lead Employer team in the workforce management and administration of medical and dental trainees. It specifically excluded processes undertaken by NWSSP Employment Services, NWSSP Primary Care Services and HEIW.
Radiopharmacy (1)	The audit sought to evaluate the progression of plans to deliver a South East Wales unit for Radiopharmacy in accordance with the objectives of the Integrated Audit Plan, as approved within the business case. This is the first of two planned reviews within that plan – the first reviewing project initiation and design
TRAMS Digital	To provide assurance over the digital elements of the TRAMS project.
Procurement Services – Declaration of Interests and Single Tender Actions	To review the adequacy and effectiveness of the control arrangements governing Single Tender Actions (STAs) and Declarations of Interest (DOIs).
Health Courier Services Vehicle Management	This audit will review and assess arrangements in place for vehicle management.
Radiopharmacy (2)	The audit sought to evaluate the progression of plans to deliver a South-East Wales Radiopharmacy unit in accordance with the Integrated Audit Plan approved within the business case. This is the second of two planned reviews within that plan – the first provided assurance in relation to project initiation and design, and this, the second, has reviewed both the outcome of the enabling works and the construction phase.

5.4 Limited Assurance (Amber)

In the following review areas, the SSPC can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Cyber Security Governance Arrangements	To provide assurance over the adequacy of governance arrangements for cyber security for the organisation.

5.5 Unsatisfactory (Red)

No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)

The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
n/a	n/a

5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Objective
Regulatory Compliance	To provide assurance over the adequacy of arrangements for the identification and monitoring of regulatory compliance.

In addition, at the time of this annual report there was one review, Medical Examiner Service, that was 'work in progress'.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the NHS Wales Shared Services Partnership to support delivery of the Internal Audit assignments undertaken within the 2025/26 plan.

James Johns
Pennaeth yr Archwiliad Mewnol/Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
June 2026

Appendix A

Internal Audit compliance with the Global Internal Audit Standards and the UK Public Sector Practice Note

Global Internal Audit Standards – Domains, Principles & Standards	Requirements & Response
Domain I: Purpose of Internal Auditing	Internal auditing strengthens the organisation's ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight. Advice and assurance are provided primarily through a risk-based audit plan approved and monitored by the Audit Committee. Audit & Assurance uses the results of its audits, together with focused research, to provide insight and foresight.
Domain II: Ethics & Professionalism Principles 1 (Demonstrate Integrity), 2 (Maintain Objectivity), 3 (Demonstrate Competency), 4 (Exercise Due Professional Care), and 5 (Maintain Confidentiality). 13 individual standards.	Audit & Assurance has established processes for dealing with both the ethics and professionalism of Internal Audit and the need to maintain client confidentiality. This encompasses training, declarations of interest returns, our audit processes, and the requirements (where appropriate) of professional accounting and audit bodies.
Domain III: Governing the Internal Audit Function Principles 6 (Authorised by the Board), 7 (Positioned Independently), and 8 (Overseen by the Board). 9 individual standards.	How we interact and work with each NHS Wales organisation is set out in the Internal Audit Mandate and Charter which is updated annually. There are appropriate arrangements in place for Internal Audit to act independently and interact with the Board to ensure effective Governance arrangements.
Domain IV: Manging the Internal Audit Function Principles 9 (Plan Strategically), 10 (Manage Resources), 11 (Communicate Effectively), and 12 (Enhance Quality). 16 individual standards.	The Internal Audit function for NHS Wales is managed through the NHS Wales Shared Services Partnership (NWSSP). The Audit & Assurance service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual plan is developed for each NHS Wales organisation. The annual plan gives detail of specific assignments and sets out the overall resource requirement. The audit

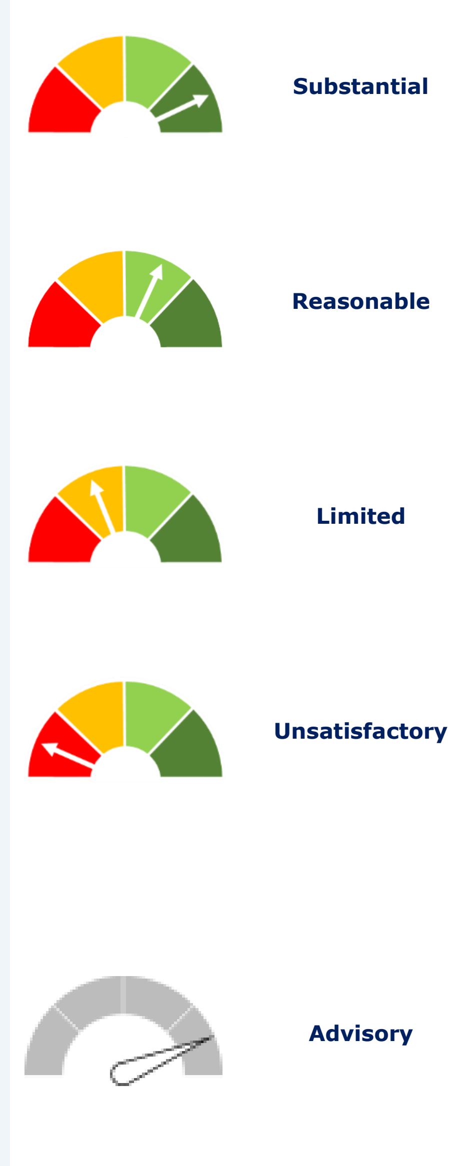
	strategy and annual plan is approved by the Audit Committee. Quality assurance and control arrangements are in place and are subject to an external assessment at least once every five years. Policies and procedures which guide the Internal Audit activity are in place. There is structured liaison with Audit Wales and Counter Fraud.
Domain V: Performing Internal Audit Services Principles 13 (Plan Engagements Effectively), 14 (Conduct Engagement Work), and 15 (Communicate Engagement Results and Monitor Action Plans). 14 individual standards.	Audit & Assurance has a Quality Manual that sets out how we will conduct and monitor audit engagements and this is then replicated in our Electronic Working Paper system (ESRA) and other files. This ensures that we meet the requirements to plan, conduct and communicate audit engagement appropriately and follow-up management actions.

Global Internal Audit Standards

UK Public Sector Application Note

Appendix B

Assurance Opinion



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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the 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 the 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.

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.

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]

MEETING	Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	15 June 2026
REPORT AUTHOR	Roxann Davies, Corporate Services Manager
RESPONSIBLE HEAD OF SERVICE	Alison Ramsey, Director of Finance and Corporate Services
PRESENTED BY	James Quance, Assistant Director of Corporate Services

TITLE OF REPORT
NWSSP Annual Governance Statement 2025-26

PURPOSE OF REPORT
To provide the NWSSP Audit Committee with the NHS Wales Shared Services Partnership's (NWSSP) Annual Governance Statement (AGS) for 2025-26, for the Committee's **APPROVAL**.

NWSSP ANNUAL GOVERNANCE STATEMENT 2025-26

1. BACKGROUND

The Shared Services Partnership Committee (SSPC) was established in accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 No. 1261(W.156) and the functions of managing and providing shared services (professional, technical and administrative services) to the health service in Wales is included within the Velindre National Health Service Trust (Establishment) (Amendment) Order 2012.

NWSSP does not have a statutory duty to produce an AGS but does so, as a matter of good governance, to provide assurance to partners and, in particular, to the Trust, as its host organisation, in relation to its governance and accountability arrangements. It provides assurance that NWSSP has a fundamentally sound system of internal control that supports the achievement of its policies, aims and objectives, and provides details of any significant internal control issues.

The AGS is signed off by the Managing Director as the NWSSP Accountable Officer, endorsed by the SSPC, and approved by the Audit Committee and the final version is reported to the SSPC.

As a hosted organisation, NWSSP's AGS supports the Trust Chief Executive in signing the Velindre University NHS Trust Annual Governance Statement. In addition, the Managing Director provides an Annual Compliance Statement to the Trust Chief Executive which was completed and returned in respect of 2025-26 on 10 April 2026.

The Head of Internal Audit reports an independent annual opinion to the NWSSP Accountable Officer, Velindre University NHS Trust Audit Committee for NWSSP and the SSPC on the adequacy and effectiveness of the risk management, control, and governance processes to support the AGS which is provided at the conclusion of the internal audit programme for the year.

The Head of Internal Audit Opinion for 2025-26 provides 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. These have a low to moderate impact on residual risk exposure until resolved.

The NWSSP Annual Governance Statement for 2025–26 is presented at **Appendix 1**, for the Committee's **APPROVAL**.

2. TIMELINE AND CONSULTATION

The governance journey for the NWSSP Annual Governance Statement (AGS) 2025-26 commenced with evidence collation, report drafting and year-end closure activity during April 2026.

An early draft was presented to Formal Senior Leadership Group (SLG) on 23 April 2026 for noting and feedback, pending finalisation of year-end datasets, followed by a draft to SSPC on 14 May 2026 for noting and feedback.

Following incorporation of feedback, it was presented to the Formal SLG on 28 May 2026 for endorsement and is now presented at the extraordinary meeting of the NWSSP Audit Committee, for formal approval.

The final publication will subsequently be noted by the SSPC at the meeting scheduled for 16 July 2026. Following approval, the document will be translated and published on the NWSSP website accordingly.

As part of the above process, the AGS is provided to Velindre University NHS Trust for assurance purposes in support of the Trust's Annual Report and Accounts.

This timetable has supported progressive consultation and engagement throughout the governance process, ensuring that early sight of draft iterations shared at key stages enabled visibility, scrutiny and feedback from relevant governance forums. Comments received through Formal SLG and SSPC have informed the refinement of the document ahead of endorsement and approval, helping to round off the overall governance journey and strengthen assurance in advance of final sign-off.

3. GOVERNANCE & RISK

The Managing Director of NWSSP, as head of the Senior Leadership Group, reports to the SSPC and Chair in relation to those functions delegated to him by the SSPC and is responsible for the overall performance of NWSSP. The Managing Director is the designated Accountable Officer for NWSSP. The Annual Governance Statement of the NWSSP Managing Director is also an important source of assurance for Velindre University NHS Trust as host regarding arrangements for governance, risk management and internal control within NWSSP.

4. RECOMMENDATION

The Committee is requested to **APPROVE** the NWSSP Annual Governance Statement 2025-26.

NHS Wales Shared Services Partnership

Annual Governance Statement 2025-26

No.	Governance Journey
1	**Formal Senior Leadership Group on 23 April 2026** ***Draft noted and feedback provided***
2	**Shared Services Partnership Committee on 14 May 2026** ***Draft noted and feedback provided***
3	**Formal Senior Leadership Group on 28 May 2026** ***Final draft endorsed by Senior Leadership Group***
4	**NWSSP Audit Committee on 15 June 2026** ***Final for approval***
5	**Shared Services Partnership Committee on 16 July 2026** ***Final for noting***

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ANNUAL GOVERNANCE STATEMENT 2025-2026

1. SCOPE OF RESPONSIBILITY

This Annual Governance Statement details the arrangements in place during 2025-26 to discharge my responsibilities as the Managing Director of the NHS Wales Shared Services Partnership (NWSSP) and to manage and control its resources in my capacity as Accountable Officer within the governance and accountability framework in place throughout the year and through a hosting arrangement with Velindre University NHS Trust (the Trust).

NWSSP does not have a statutory duty to produce an Annual Governance Statement but does so, as a matter of good governance, to provide assurance to partners and, in particular, to the Trust, as its host organisation, in relation to its governance and accountability arrangements.

As Accountable Officer, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned to me by the Accountable Officer of NHS Wales.

Governance comprises the arrangements put in place to ensure that the intended outcomes for stakeholders are defined and achieved. Effective governance is paramount to the successful and safe operation of NWSSP's services. This is achieved through a combination of "hard" systems and processes including Standing Orders, policies, protocols, and processes; and "soft" characteristics of effective leadership and high standards of behaviour (driven by the Nolan principles).

In addition to my responsibilities as Accountable Officer I am accountable for my performance and that of NWSSP to the Shared Services Partnership Committee (SSPC) and its Chair in relation to those functions delegated to it.

I also have responsibility with the Chief Executive of Velindre University NHS Trust (the Trust) to co-operate together to ensure the success of the hosting arrangement in the interest both of the NHS in Wales generally and the local interests of the Trust as host. In practice this means that I have a responsibility to provide information to the Chief Executive of the Trust where he has a legitimate interest as Accountable Officer of the Trust, whilst ensuring that he does not intervene in the activity of shared services.

The Chief Executive of the Trust is responsible for the overall performance of the executive functions of the Trust and is the designated Accountable Officer for the Trust. As the host organisation, the Chief Executive (and the

Trust Board) has a legitimate interest in the activities of NWSSP and has certain statutory responsibilities as the legal entity hosting NWSSP.

Myself (as the Accountable Officer for NWSSP) and the Chief Executive of the Trust (as the Accountable Officer for the Trust) shall be responsible for meeting all the responsibilities of our roles, as set out in our respective Accountable Officer Memoranda. Both Accountable Officers co-operate with each other to ensure that full accountability for the activities of NWSSP and the Trust is afforded to the Welsh Government Ministers/Cabinet Secretary whilst minimising duplication.

2. GOVERNANCE FRAMEWORK

NWSSP is not 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.

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)) and the Trust's Standing Order 3 into day-to-day operating practice. 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 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.

2.1 Welsh Government Independent Review of NHS Wales Shared Services 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 in order 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.

Welsh Government accepted, subject to further consideration, the majority of the Review's recommendations and published its Initial Response alongside the Review. The recommendations include a number of core themes, including:

- strengthening the appointment, role clarity and performance oversight of the SSPC Chair, including appropriate involvement of Velindre;
- clarifying Integrated Medium-Term Plan (IMTP) approval and assurance arrangements, including formal endorsement or noting by NHS Boards following SSPC approval;
- strengthening performance reporting and assurance routes from NWSSP, through the SSPC, to constituent NHS Boards;
- ensuring appropriate and consistent governance arrangements where services are provided that are deemed to contain clinical components, with clear links to Board-level assurance;

- clarifying processes for the addition of new services to the shared services portfolio through established planning and approval mechanisms, including the IMTP; and
- updating governance documentation.

Further information on the Independent Review and Welsh Government's Initial Response is published on the Welsh Government website: https://www.gov.wales/independent-review-nhs-wales-shared-services-partnership

In response to the Review, Welsh Government established a Welsh Government-led Review Implementation Group (The Group) to oversee, coordinate and support delivery of the accepted recommendations. The Implementation Group includes senior representation from Welsh Government, NWSSP and Velindre University NHS Trust, with governance and legal advisers attending as appropriate. The Group does not hold formal decision-making authority; where approvals are required, these continue to be progressed through established governance routes, including the SSPC and constituent NHS Boards, until any changes are formally agreed and implemented.

The Group first met in February 2026, agreed its terms of reference and translated the Review recommendations into a structured, time-bound programme of work with the intention to complete the implementation of the recommendations over a six month timescale.

Progress is reported regularly to the SSPC, with items requiring SSPC consideration or approval being brought forward through formal committee papers. In line with Welsh Government's Initial Response, arrangements have been put in place to strengthen Board-level assurance of the NWSSP IMTP. The NWSSP IMTP was approved by the SSPC on 19 March 2026 and noted by Velindre University NHS Trust Board on 26 March 2026 following a presentation by Directors from NWSSP.

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

2.2 Shared Services Partnership Committee (SSPC)

Whilst the SSPC acts on behalf of all NHS organisations in undertaking its functions, the responsibility for the exercise of NWSSP functions is a shared responsibility of all NHS bodies in Wales.

The purpose of the SSPC is set out below:

- to set the policy and strategy for NWSSP within the legal framework the Trust, as host, operates under;

- to monitor the delivery of shared services through the Managing Director of NWSSP;
- to seek to improve the approach to delivering shared services which are effective, efficient and provide value for money for NHS Wales and Welsh Government;
- to ensure the efficient and effective leadership, direction, and control of NWSSP; and
- to ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The SSPC monitors performance against key performance indicators. For any indicators assessed as being below target, reasons for current performance are identified and included in the report along with any remedial actions to improve performance. Deep Dive sessions are often on the agenda to learn more about the opportunities, risks and issues of services within NWSSP, examples of which are shown in the SSPC Performance section below.

The SSPC ensures that NWSSP consistently follows the principles of good governance applicable to NHS organisations, including the oversight and development of systems and processes for financial control, organisational control, governance, and risk management. The SSPC assesses strategic and corporate risks through review of the NWSSP Corporate Risk Register at each meeting.

The composition of the SSPC includes an Independent Chair, the Managing Director of Shared Services, and the Chief Executive of each partner organisation. There is provision in the SSPC Standing Orders for Chief Executives to nominate a deputy to act on their behalf which has been exercised by most organisations. Nominated deputies for Chief Executives should be an Executive Director of the same organisation and formally contribute to the quorum and have delegated voting rights.

The membership of the SSPC during the year ended 31 March 2026 is outlined in Figure 3 below.

Figure 3: Membership of the NHS Wales Shared Services Partnership Committee during 2025-26

Name	Position	Organisation	Full/Part Year
Tracy Myhill OBE	SSPC Chair	NHS Wales Shared Services Partnership	Full Year
Huw Thomas	Director of Finance and Deputy Chief Executive (Vice Chair)	Hywel Dda University Health Board	Full Year
Neil Frow OBE	Managing Director and NWSSP Accountable Officer	NHS Wales Shared Services Partnership	Full Year
Sarah Simmonds	Executive Director of Workforce and Organisational Development	Aneurin Bevan University Health Board	Full Year

Name	Position	Organisation	Full/Part Year
Russell Caldicott	Executive Director of Finance	Betsi Cadwaladr University Health Board	Full Year
Catherine Phillips	Executive Director of Finance	Cardiff and Vale University Health Board	Full Year
Sally May	Executive Director of Finance	Cwm Taf Morgannwg University Health Board	Part Year
Claire Osmundsen-Little	Executive Director of Finance	Digital Health and Care Wales	Part Year
Chris Moreton	Interim Director of Finance	Digital Health and Care Wales	Part Year
Glyn Jones	Director of Finance, Planning and Performance	Health Education and Improvement Wales	Full Year
Pete Hopgood	Executive Director of Finance and Business Assurance	Powys Teaching Health Board	Full Year
Paul Veysey*	Board Secretary and Head of the Board Business Unit	Public Health Wales	Full Year
Sarah Jenkins	Interim Director of Workforce and Organisational Development	Swansea Bay University Health Board	Part Year
Tina Ricketts	Director of Workforce and Organisational Development	Swansea Bay University Health Board	Part Year
Carl James	Interim Chief Executive	Velindre University NHS Trust	Part Year
David Donegan	Chief Executive	Velindre University NHS Trust	Part Year
Chris Turley	Executive Director of Finance and Corporate Resources	Welsh Ambulance Services NHS Trust	Full Year

**Not an Executive Director*

The Committee meets bi-monthly and Welsh Government and Trade Union representatives, whilst not members of the Committee, have a standing invitation and are in regular attendance.

The Committee also requires the attendance of the following NWSSP officers: the Director of Finance and Corporate Services; the Director of People, Organisation Development and Employment Services; the Medical Director; the Director of Planning, Performance and Informatics; and the Assistant Director of Corporate Services.

Figure 4 – Attendance at the Meetings of the NHS Wales Shared Services Partnership Committee during 2025-2026

Organisation	22/05/2025	17/07/2025	30/09/2025	14/11/2025	22/01/2026	19/03/2026
SSPC Chair	✓	✓	✓	✓	✓	✓
NWSSP Managing Director and Accountable Officer	✓	✓	✓	✓	✓	✓
Aneurin Bevan University Health Board	✓	✓	✓	✓	✓	x
Betsi Cadwaladr University Health Board	x	✓**	✓**	✓**	x	✓
Cardiff and Vale University Health Board	✓**	✓**	✓**	✓**	✓**	✓**
Cwm Taf Morgannwg University Health Board	x	✓	✓	✓	✓	✓*
Digital Health & Care Wales	✓	✓	✓	✓	✓	✓
Health Education & Improvement Wales	✓	✓	✓	✓**	✓	✓
Hywel Dda University Health Board	✓	✓**	✓	✓**	✓**	✓
Powys Teaching Health Board	x	✓**	✓	✓	✓**	✓
Public Health Wales	x	✓	✓	✓	✓	✓
Swansea Bay University Health Board	✓**	✓	x	✓	✓**	✓*
Velindre University NHS Trust	x	✓*	✓*	✓*	✓	✓
Welsh Ambulance Service Trust	✓	✓	✓	✓**	✓	✓**
Welsh Government	✓	✓	✓	✓	✓	✓
Trade Union	x	✓	x	✓	x	x

✓ Denotes the nominated member was present

✓* *Denotes the nominated member was not present and that an alternative Executive Director attended on their behalf*

✓** *Denotes that the nominated member was not present and that while a deputy did attend, they were not an Executive Director.*

X Denotes Health Body not represented

All meetings of the SSPC during the 2025-26 met the quoracy requirements of the SSPC Standing Orders. Following each meeting the SSPC Chair provides an assurance report to partner organisation boards.

In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the SSPC is required to meet in public. Arrangements are made for the public to attend should an appropriate request be received. We did not receive any such requests from the public to attend the SSPC in 2025-26 but to ensure business was conducted in as open and transparent manner as possible during this time the following actions were taken:

- the dates of all meetings are published on the NWSSP website prior to the start of the financial year;
- the agenda is published at least seven days prior to the meeting, where possible; and
- all papers are published in English on the website, and minutes and agendas are also provided in Welsh, shortly after the meeting has taken place.

2.3 SSPC Performance

At the start of 2025-2026, the SSPC approved an annual forward plan of business, including:

- Regular assessment and review of:
    - Finance, Workforce and Outcome Measures and Performance Information;
    - Quarterly Integrated Medium-Term Plan progress reports:
    - Corporate Risk Register;
    - Welsh Risk Pool; and
    - Transformation Management Office updates.
- Annual review and/or approval of:
    - Integrated Medium-Term Plan;
    - Annual Governance Statement;
    - Audit Wales Management Letter;
    - Annual Review;
    - NWSSP Strategy Refresh for 2026-29
    - Standing Orders; and
    - Service Level Agreements.
- Deep Dives (nominated and suggested topics from SSPC members as events dictate) including:
    - Operational Planning for the Central Procurement of Flu Vaccines;
    - Review of NWSSP Accountability and Governance Arrangements; and
    - Integrated Medium-Term Plan.
- Autumn Development Day, held in October 2025, which was delivered under the theme of "*Delivering Value, Innovation and Excellence through Partnership*" and provided a dedicated forum for Members to reflect on and inform the strategic direction of NWSSP, with the agenda including:
    - Review and refresh of the NWSSP Strategy Map;
    - Consideration of the Ministerial Advisory Group (MAG) Report and organisational priorities;

- Discussion on how NWSSP can support health organisations in delivering their plans;
- Update on Transforming Access to Medicines Service (TrAMS);
- Presentation on the Future Workforce Solution - Electronic Staff Record (ESR); and
- Collective reflections to inform strategic direction and continuous improvement.

There are a number of sources of feedback and assurance over the operation of the SSPC which were in place during the year:

- the Welsh Government Review referred to above;
- Assurance Reports from each SSPC meeting to each partner organisation;
- regular liaison with SSPC members by the SSPC Chair, Managing Director and members of the Senior Leadership Group;
- review of agendas and papers by external and internal audit for the purposes of their audits; and
- arrangements for the annual SSPC Chair's appraisal remained in place following the reporting of the last reported to the March 2025 SSPC meeting.

The arrangements for the appraisal of the SSPC Chair were reviewed as part of the Welsh Government-commissioned independent review of NWSSP governance and accountability arrangements and a recommendation was made to update the element relating to providing host assurance to the Velindre Chair on the operation of the SSPC, and this work is being progressed through the Review Implementation Group in order to be applicable to the successor to Tracy Myhill OBE during 2026-27.

The Chair of SSPC and Managing Director are committed to continuous improvement and where identified changes are made to improve the operation of the Committee. In general terms, feedback received from members continues to be positive and members are content that the SSPC covers the areas expected, meetings are chaired well and contributions and discussion are appropriate.

2.4 SSPC Sub-Committees

The SSPC has established a Sub-Committee structure that meets its own advisory and assurance needs and utilises the Trust's committee arrangements to assist it in discharging its governance responsibilities. The arrangements in place ensure that the SSPC Sub-Committee structure meets the needs of the Trust, as the host organisation, and also the needs of its Partners.

As a minimum, the SSPC Standing Orders require an Audit Committee to be in place. In addition, the SSPC has established the Welsh Risk Pool Committee as a formal Sub-Committee.

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

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. This is 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 Audit Committee reviews the effective local operation of internal and external audit, as well as Local Counter Fraud Services. In addition, it ensures that a professional relationship is maintained between the external and internal auditors so that assurance resources are effectively used.

The Audit Committee supports the SSPC in its decision-making and in discharging its accountabilities for securing the achievement of NWSSP's objectives in accordance with the standards of good governance determined for the NHS in Wales.

After each meeting of the Committee, the Chair of the Committee provides an Assurance Report to the SSPC and to each meeting of the Velindre University NHS Trust Board for assurance and to highlight any areas of concern from the business of the Committee to the host organisation.

The Audit Committee attendees during 2025-26 comprised of two Independent Members of the Trust (the members of the Committee), with representatives of both Internal and External Audit and Senior Officers of NWSSP and the Trust in attendance. The Audit Committee met formally on four occasions as planned during the year.

Figure 5 - Composition of the Velindre University NHS Trust Audit Committee for NWSSP during 2025-2026

In Attendance	16/04/2025	08/07/2025	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**

In Attendance	16/04/2025	08/07/2025	07/11/2025	10/02/2026	Total
NWSSP Counter Fraud Services					
Local Counter Fraud Specialist	✓	✓	✓	✓	**4/4**
NWSSP					
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	✓	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**

*Unable to attend due to the February meeting being re-arranged

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.

2.4.2 Reviewing Effectiveness of Audit Committee

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, Independent Members and 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.

2.4.3 The Welsh Risk Pool Committee

On 1 April 2019, the National Health Service Clinical Negligence Scheme Wales Regulations 2019 came into force. The Regulations created a Scheme for Clinical Negligence Claims in Wales and were brought into force among other things for the management of clinical negligence claims in Wales, operating under sections 41, 42 and 50 of the National Health Service Wales Act 2006.

The scheme is operated by NWSSP through Legal and Risk Services with the support of the Welsh Risk Pool using its powers as a shared service function under the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012.

NWSSP has responsibility for the administration of the Welsh Risk Pool Service including the management of the Welsh Risk Pool Budget. The Welsh Risk Pool is funded through the NWSSP financial allocation from Welsh Government supplemented by a Risk Sharing Agreement with Health Boards and Trusts.

The Welsh Risk Pool Committee comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal & Risk Services and the Welsh Government. The Terms of Reference of the Committee explain the primary role of the Welsh Risk Pool Committee:

- to reimburse losses over £25,000 incurred by Welsh NHS bodies arising out of negligence;
- to provide oversight of the GP Indemnity Scheme;
- to oversee the work and expenditure of the Welsh Risk Pool; and
- to help to promote best clinical practice and lessons learnt from clinical incidents.

Reporting from the Welsh Risk Pool to the SSPC has been standardised during the year with an update from each meeting by the NWSSP Managing Director as the Accountable Officer for the Welsh Risk Pool.

During 2025–26, the financial position of the Welsh Risk Pool continued to present a significant challenge, reflecting wider system pressures and

ongoing volatility within the clinical negligence landscape. These pressures, including rising costs of settling claims, were a key focus for the Shared Services Partnership Committee (SSPC) throughout the year. The Committee received regular reports to support scrutiny of the financial position, emerging risks and mitigating actions. Addressing the financial sustainability of the Welsh Risk Pool remains a priority moving into 2026–27, with continued focus on funding arrangements, claims management, risk reduction and long-term financial planning, overseen through established governance and assurance arrangements.

2.5 SSPC Advisory Groups

The SSPC is supported by two advisory groups:

- **Local Partnership Forum (LPF)**

The LPF is a formal mechanism for consultation and engagement between NWSSP and the relevant Trade Unions as set out in the SSPC Standing Orders. The LPF facilitates an open forum in which parties can engage with each other to inform debate and seek to agree local priorities on workforce and health service issues.

- **Welsh Energy Group (WEG)**

The WEG is a Task and Finish Advisory Group as set out in the Shared Services Partnership Committee (SSPC) Standing Orders. Its role is to:

- Agree the energy purchasing strategy for NHS Wales.
- Monitor the performance of contractual arrangements.
- Receive reports on market conditions from the provider of the existing Supply of Energy contract/s to inform the purchasing strategy.
- Receive reports on forecast costs, good practice and any concerns around supplier performance from the Wales Energy Operational Group (WEOG).
- Escalate formally concerns relating to supplier performance, that have not been able to be resolved through the WEOG arrangements.
- Establish task and finish groups as required, to undertake specific tasks with clear timelines for reporting.
- Agree NHS Wales nominations to any route of supply governance arrangements currently the External Risk Management Group (ERMG) and Commodity Trading Governance Board (CTGB).
- Receive reports on the discussions of the ERMG and CTGB groups.
- Make recommendations for agreed matters to be approved by the Shared Services Partnership Committee and, otherwise report by exception to the Shared Services Partnership Committee.

The Terms of Reference for both groups were reviewed, updated and approved by the SSPC during 2025-26.

2.6 Velindre University NHS Trust Quality, Safety and Performance Committee

In addition to the above, NWSSP provides targeted assurance to the Velindre University NHS Trust Quality, Safety and Performance Committee (QSP) in relation to services with a clinical or quality governance component.

During 2025–26, the Committee received updates on the implementation of the Duty of Quality, including a bi-annual update and the Duty of Quality Annual Report. The Committee also received reports relating to the Medical Examiner Service (annual and exception reporting) and Surgical Materials Testing Laboratory (annual reporting), providing assurance on governance, safety, quality and regulatory compliance arrangements.

In addition, updates were provided on All-Wales Pharmacy Services, including Transforming Access to Medicines (TrAMs), reflecting the increasing focus on assurance in relation to nationally delivered pharmacy services. NWSSP also presented papers setting out the governance arrangements for clinical support services delivered by NWSSP and the associated host assurance routes. This approach will continue into 2026–27, with a sustained focus on Pharmacy Services, Duty of Quality compliance and clinical governance arrangements.

2.7 All Wales Purchase to Pay (P2P) Governance

The All Wales P2P Governance Forum was established in 2024 to progress P2P initiatives across Wales on a Once for Wales basis to improve and streamline efficiencies and opportunities. The All-Wales P2P Governance Group reports into the Deputy Directors of Finance Forum for agreement of changes proposed, with the overarching high-level governance continuing to operate through the Shared Services Partnership Committee.

2.8 Senior Leadership Group

The Managing Director reports to the Chair of the SSPC and is responsible for the overall performance of NWSSP and is accountable to the SSPC in relation to those functions delegated to them by the SSPC. The Managing Director determines and leads a Senior Leadership Group to deliver the SSPC's annual Business Plan as set out in the Integrated Medium-Term Plan approved by SSPC. The Managing Director is the designated Accountable Officer for NWSSP and is accountable, through the leadership of the Senior Leadership Group, for:

- the performance and delivery of NWSSP through the preparation of the annually updated Integrated Medium-Term Plan (IMTP) based on the policies and strategy set by the SSPC and the preparation of Service Improvement plans;
- leading the SLG to deliver the IMTP and Service Improvement Plans;
- establishing an appropriate Scheme of Delegation for the SLG; and

- ensuring that adequate internal controls and procedures are in place to ensure that delegated functions are exercised properly and prudently.

The SLG during 2025-26 comprised:

Figure 7 – Composition of the Senior Leadership Group during 2025-26

Name	Designation
Neil Frow OBE	Managing Director
Alison Ramsey	Director of Finance and Corporate Services
Gareth Hardacre	Director of People, Organisation Development and Employment Services
Rebecca Nelson	Director of Planning, Performance and Informatics
Jonathan Irvine	Director of Procurement, Supply Chain Logistics and Transport and Laundry Services
Simon Cookson	Director of Audit and Assurance Services
Mark Harris	Director of Legal and Risk Services and Welsh Risk Pool
Nicola Phillips	Director of Primary Care Services and Medical Examiner Services
Stuart Douglas	Director of Specialist Estates Services
Dr Ruth Alcolado	Medical Director
Dr Gavin Hughes	Director of Surgical Materials Testing Laboratory
Colin Powell	Director of Pharmacy Technical Services *(To 31 October 2025)*
Laura-Jayne Keating	Director of Pharmacy Technical Services *(From 1 November 2025)*
James Quance	Assistant Director of Corporate Services
Alwyn Hockin	Trade Union Representative
Claire Daw	Trade Union Representative

During the course of the year, the Terms of Reference of the SLG were reviewed in order to ensure that they are fit for purpose, with the next planned review date being May 2026.

3. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to the achievement of the policies, aims and objectives of NWSSP. Therefore, it can only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks, evaluate the likelihood of those risks being realised and the impact they would have, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in NWSSP for the year ending 31 March 2026 and up to the date of approval of the Trust Annual Report and Accounts.

3.1 External Audit

NWSSP's external auditors are Audit Wales. The Audit Committee has worked constructively with Audit Wales and the areas examined in the 2025-26 financial year included:

- Position Statements (to every meeting);
- NWSSP Nationally Hosted NHS IT Systems Assurance Report;
- Management Letter 2024-25; and
- Assurance Arrangements 2025-26.

The work of external audit is monitored by the Audit Committee through regular progress reports. Their work is considered timely and professional. The recommendations made are relevant and helpful in our overall assurance and governance arrangements and in minimising risk. There are clear and open relationships with officers and the reports produced are comprehensive and well presented. No matters were raised in the 2024-25 Management Letter.

In addition to internal NWSSP issues, the Audit Committee has been kept appraised by external auditors of developments across NHS Wales and elsewhere in the public sector. These discussions have been helpful in extending the Audit Committee's awareness of the wider context of our work.

3.2 Internal Audit

NWSSP's Internal Audit service is provided by the Audit & Assurance Division of NWSSP, as it is for all NHS Wales organisations. The Audit Committee review and consider the work and findings of the Internal Audit team at each meeting and progress against the approved Internal Audit Plan. The Director of Audit and Assurance and the Head of Internal Audit attend Audit Committee meetings to discuss their work and present their findings. The Audit Committee is satisfied with the liaison and co-ordination between the external and internal auditors.

Quarterly returns providing assurance on any audit areas assessed as having "no assurance" or "limited assurance" were issued to Welsh Government in accordance with the instruction received in July 2016. During 2025-26, there was one internal audit report rated as limited assurance in respect of cyber security governance arrangements, and there were zero internal audit reports with no assurance.

For both internal and external audit, the Audit Committee has ensured that management actions agreed in response to reported weaknesses were implemented in a timely manner. Any planned revisions to agreed timescales for implementation of action plans require Audit Committee approval. A report on the position with implementation of agreed management actions in response to audit key findings, is monitored at each monthly meeting of the SLG and each meeting of the Audit Committee.

Reports were timely and enabled the Audit Committee to understand operational and financial risks. In addition, the internal auditors have provided valuable benchmarking information relating to best practice across NHS Wales. As at 31 March 2026, the total number of agreed management actions arising from audit findings identified was 123. Of which, 112 were implemented, 8 were not yet due and 3 were overdue (not fully within the control of NWSSP, as delivery is dependent on third-party organisations), demonstrating that actions are being implemented in a timely manner.

The required five-yearly external quality assessment of Internal Audit was most recently undertaken by the Chartered Institute of Public Finance & Accountancy during the 2023/24 period against the Public Sector Internal Audit Standards (the Standards) and resulted in the highest possible rating being awarded to the Service. There were no areas of either partial or non-compliance noted with the Standards.

The Director of Audit & Assurance reports annually to the Audit Committee with the results of an internal quality review, the most recent of which was reported to the Committee in February 2026 providing an update on the two external quality assessment advisory findings and a quality review of 16 audit files covering all NHS Wales organisations. Overall, the results were positive and demonstrated a high level of quality consistent with recent years. In a small number of instances, discussions were needed with the Head of Internal Audit to confirm findings and minor exceptions were noted. Based on the reviews undertaken, there were no specific matters that needed to be reported in the Annual Head of Internal Audit opinion in terms of compliance with the Standards.

3.3 Counter Fraud

The work of the Local Counter Fraud Service (LCFS) is undertaken to help reduce and maintain the incidence of fraud and/or corruption within NWSSP to an absolute minimum. Counter Fraud activity in NWSSP is primarily undertaken by its own dedicated Local Counter Fraud Manager with links to the wider network of counter fraud professionals in NHS Wales and the National Counter Fraud Service.

Regular reports were received by the Audit Committee to monitor progress and demand against the agreed Counter Fraud Plan, including the following:

- Annual Report 2024-25;
- Progress Update at each meeting; and
- Counter Fraud Work Plan 2025-26.

As part of their work, the Local Counter Fraud Manager has a regular annual programme of raising fraud awareness for which a number of days are then allocated and included as part of an agreed Work Plan which is approved by the Director of Finance and Corporate Services and Audit Committee

annually. The balance of the plan is weighted towards proactive and preventative activity, education and awareness.

As part of that planned area of work, regular fraud awareness sessions are arranged and then held with various staff groups at which details on how and to whom fraud can be reported are outlined. During 2025-26, these sessions have been provided both in face-to-face sessions and virtually. In total during 2025-26 there were 6,307 fraud awareness interactions with staff (1,557 in 2024-25). The number of interactions is significantly larger in 2025-26 due to the increased use of newsletters, emails, Sharepoint blogs and other media.

In addition to this, and to continue to promote an Anti-Fraud Culture within NWSSP, a newsletter is produced periodically which is available to all staff on the intranet and all successful prosecutions are publicised in order to obtain the maximum deterrent effect. The SLG targeted staff groups to complete the e-learning module on Counter Fraud, with over 1,400 staff having completed the module at the end of March 2026.

Assessment of the Counter Fraud Functional Standards provides assurance that NWSSP is compliant overall, noting that the Counter Fraud risk assessment remains assessed as Amber. The risk assessment is in place and feeds into the Counter Fraud workplan for 2025-26, with further work ongoing to enhance its maturity.

3.4 Quality Assurance

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduced the Duty of Quality which came into effect from the 1 April 2023. The Duty applies to clinical and non-clinical NHS Services, and therefore the services and functions of NWSSP are captured by this legislation. An Annual Report outlining compliance with the Duty is produced and reported to Welsh Government through the Annual Quality Report of Velindre University NHS Trust, the hosting body.

Under the requirements of the Act, primary responsibility rests with the Managing Director as the Accountable Officer, and the Medical Director is the lead for strategic direction and oversight. Oversight is through the SSPC. The responsibility to report is two-fold – both internally in respect of our own quality measures but also externally in terms of providing information for Health Boards and Trusts to report their own performance. In addition, the Trust as our host has a legitimate interest in our quality arrangements.

The SSPC gives attention to assuring the quality of services by including a section on "Quality, Safety and Patient Experience" as one of the core considerations on the committee report template when drafting reports for SSPC meetings.

The Velindre Quality, Safety and Performance Committee allocates part of its meetings to NWSSP matters.

In addition, quality of service provision is a core feature of the discussions undertaken between NWSSP and the Health Boards and Trusts during quarterly review meetings with the relevant Directors. With the introduction of the Duty of Quality, this has become a more prominent feature, and bi-annual presentations on this subject have been made to the Shared Services Partnership Committee.

In addition to corporate governance arrangements for risk management and control, Procurement Services maintains compliance and certification with a number of national and international standards as appropriate to the provision of its services. They include ISO 9001 Quality Management Standard, BS ISO 45001 Occupational Health and Safety and Customer Service Excellence.

NWSSP's regional warehouses and national distribution centre at Newport are also accredited to the STS Food Safety Standard for the storage and distribution of food products. The receipt, storage and distribution of pharmaceuticals and controlled drugs at designated warehouses are compliant with Good Distribution Practice and Medicines and Healthcare products Regulatory Agency (MHRA) and Home Office licence conditions.

Compliance with these standards and their associated audit by external bodies is supported and assured by a robust internal audit plan that highlights any areas of non-compliance and improvement opportunities. The Quality Plan includes improvement objectives that are reviewed each year to ensure that they are aligned and continue to support strategic objectives for the Division.

3.5 Certifications

NWSSP holds a number of certifications corporately that support the delivery and continual improvement of quality services, including attainment of organisational accreditations to the Cabinet Office accredited Customer Service Excellence (CSE) Standard and International Organisation for Standardisation (ISO) 14001:2015 Environmental Management Standards.

Many services within NWSSP also hold independently verified certifications and standards, including ISO27001 Information Security Management, ISO9001 Quality Management, ISO11014 Material and Safety Data Sheet, ISO45001 Health and Safety Management, ISO14065 Risk Analysis and Biocontamination Control (RABC) in Laundries and ISO17025 Testing and Calibration of Laboratories Standards. External audit reviews included Carriage of Dangerous Goods Licensing, Public Sector Internal Audit Standards (PSIAS) and NWSSP is also an accredited Mental Health First Aid Trainer organisation.

Key organisational achievements for embedding the Duty of Quality in 2025-26 included continued raising of awareness with the Shared Services Partnership Committee, Senior Leadership Group and divisions, Quality

Champions Network for sharing best practice, creation of video submissions by Services detailing their quality measures, quality driven reporting and consideration of our 'always on' performance measures, quality control and using data for quality improvement and external quality reviews, certifications and awards as a source of assurance and opportunity for further improvement. Reporting is further enhanced by the inclusion of the Duty of Quality as part of the quarterly reporting processes within NWSSP. This places consideration of the domains and enablers of quality on an equal basis with finance and performance.

NWSSP has also been developing an overarching Quality Management System (QMS) which outlines the organisational approach and enables each division to manage their own QMS in accordance with external accreditation and inspections. This will be embedded further in 2026-27. The Duty has been further strengthened by being included for consideration as part of the Equality Integrated Impact Assessment, which meets the requirements of the Act to consider the Duty when undertaking any strategic planning.

3.6 Customer Service Excellence

In October 2023, NWSSP was accredited with an organisational level Customer Service Excellence (CSE) Award, making it the first organisation within NHS Wales to achieve the highly valued government standard.

The CSE accreditation assesses organisations and measures customer focused areas that research has identified as a priority to customers with a particular focus on:

- Customer Insight;
- Culture of the Organisation;
- Information and Access;
- Delivery and Timeliness; and
- Quality of Service.

Within this framework, CSE also prioritises three distinct areas, as a driver of continuous improvement, as a skills development tool and, as an independent validation of achievement. The second annual reassessment took place in October 2025, with NWSSP maintaining certification to the Standard.

As part of the reassessment process, NWSSP achieved 12 Compliance Pluses, demonstrating that the organisation exceeded the standards required, evidencing maturity and embedded practice. NWSSP also achieved 45 Compliances, where in each instance the standard required was met, with zero Partial Compliances to consider as areas of improvement.

4. CAPACITY TO HANDLE RISK

The Corporate Risk Register is reviewed at each meeting of the Formal SLG, SSPC and Audit Committee to ensure that the key risks are aligned to

delivery and are appropriately considered and scrutinised. The register is divided into two sections as follows:

- **Risks for Action** – this includes all risks where further action is required to achieve the target score. The focus of attention for these risks should be on ensuring timely completion of required actions; and

- **Risks for Monitoring** – this is for risks that have achieved their target score, but which need to remain on the Corporate Risk Register due to their potential impact on the organisation as a whole. For these risks the focus is on monitoring both any changes in the nature of the risk (e.g. due to external environmental changes) and on ensuring that existing controls and actions remain effective (e.g. through assurance mapping).

As at 31 March 2026, there were six red rated risks on the NWSSP Corporate Risk Register, as set out below:

- the threat of a successful cyber-attack leading to potential loss of systems and/or sensitive data which could have an impact of service delivery;
- the risk that there may be disruption to the supply of pharmaceuticals caused by external factors, resulting in significant restrictions to provision;
- the threat to patient services if the planned developments of the Radiopharmacy and Transforming Access to Medicines Services (TrAMS) hub is not allowed to progress, due to funding or planning limitations;
- the planned development of the TrAMS Pharmacy Service is adversely impacted, due to financial and staffing challenges;
- the challenges in scaling support for the Future Workforce Solution rollout (replacement of ESR), risks from limited user organisation capacity that may hinder implementation success, and uncertainties around contract management and funding that require clarification from Welsh Government colleagues; and
- the reputational risk for NWSSP regarding the forecast accuracy for the Welsh Risk Pool.

The SSPC has overall responsibility and authority for NWSSP's Risk Management programme through the receipt and evaluation of reports indicating the status and progress of risk management activities.

The Lead Director for risk is the Director of Finance and Corporate Services who is responsible for establishing systems and processes needed for the management of risks within the organisation.

The Trust has an approved strategy for risk management and NWSSP has a Risk Management Protocol in line with its host's strategy providing a clear systematic approach to the management of risk within NWSSP. At the time of writing, NWSSP is awaiting an update to the Trust's overarching risk

management strategy and supporting policy framework, which is planned for 2026–27, and will review and update its local protocol, as required, to ensure continued alignment.

NWSSP seeks to integrate risk management processes so that it is not seen as a separate function but rather an integral part of the day-to-day management activities of NWSSP including financial, health and safety and environmental functions as well as business continuity and cyber security risks.

It is the responsibility of each Director and Head of Service to ensure that risk is addressed within each of the locations relevant to their Directorates. It is also important that an effective feedback mechanism operates across NWSSP so that frontline risks are escalated to the attention of Directors.

Each Director is required to provide a regular update on the status of their directorate specific risk registers during quarterly review meetings with the Managing Director. All risks categorised as red within individual directorate registers trigger a referral for review, and if deemed appropriate the risk is added to the NWSSP Corporate Risk Register for oversight by the SLG, SSPC and Audit Committee. The NWSSP Corporate Risk Register during 2025-26 had a number of risks escalated from services for monitoring by the SLG.

Directorate-level assurance maps are in place to provide visibility of how key operational and business-as-usual risks are being mitigated. While the assurance maps themselves are periodically presented to the Audit Committee, the Committee receives assurance on the effectiveness of the overall assurance-mapping process and the arrangements in place to identify, manage and monitor risk. Further assurance on this overarching approach is scheduled to be provided during summer 2026.

The SSPC also has a documented Risk Appetite Statement for NWSSP. A detailed review took place during the year within NWSSP following its last comprehensive update following the Shared Services Partnership Committee Development Day held in Autumn 2024. SSPC members continue to challenge NWSSP to be bolder in its approach to risk. The revised Risk Appetite Statement was approved at the November 2024 meeting of the SSPC and was subsequently reviewed internally and reported to the Audit Committee in April 2025. The SLG continues to undertake periodic informal deep dive sessions, reviewing its approach to managing risk and the NWSSP Corporate Risk Register. NWSSP will review and, where necessary, revise the Risk Appetite Statement during 2026–27.

During 2025–26, an internal audit of risk management arrangements within NWSSP was undertaken and Reasonable Assurance was awarded. Two recommendations were identified to further strengthen the effectiveness of the framework. These related to:

- enhancing the consistency and clarity of risk articulation and scoring, to ensure risks are described and assessed in a uniform way across

directorates and that links between operational and strategic risks are clearly evidenced; and
- clarifying the treatment of 'at target' risks, including whether they should be reclassified from 'risks for action' to 'risks for monitoring'.

NWSSP's approach to risk management therefore ensures that:

- leadership is given to the risk management process;
- staff receive training on how to identify and manage risk;
- risks are identified, assessed, and prioritised ensuring that appropriate mitigating actions are outlined on the NWSSP Corporate Risk Register;
- the effectiveness of key controls is regularly assured; and
- there is compliance with the Orange Book on Management of Risk.

5. THE CONTROL FRAMEWORK

NWSSP's commitment to the principle that risk is managed effectively means a continued focus to ensure that:

- there is compliance with legislative requirements where non-compliance would pose a serious risk;
- all sources and consequences of risk are identified, and risks are assessed and either eliminated or minimised; information concerning risk is shared with staff across NWSSP and with Partner organisations through the SSPC and the Audit Committee;
- damage and injuries are minimised, and staff health and wellbeing is optimised; and
- lessons are learnt from compliments, incidents, and claims in order to share best practice and reduce the likelihood of reoccurrence.

5.1 Corporate Risk Framework

The detailed procedures for the management of corporate risk have been outlined above. Generally, to mitigate against potential risks concerning governance, NWSSP is proactive in reviewing its governance procedures and ensuring that risk management is embedded throughout its activities, including:

- NWSSP is governed by Standing Orders and Standing Financial Instructions which are reviewed on an annual basis;
- the SSPC, Audit Committee and Velindre Quality, Safety and Performance Committee have forward work plans for committee business which provide an assurance framework for compliance with legislative and regulatory requirements for NWSSP;
- the effectiveness of governance structures is regularly reviewed including through self-effectiveness surveys;
- the front cover pro-forma for reports for the SSPC includes a summary impact analysis section to be completed prior to submission. This provides a summary of potential implications relating to equality and diversity, legal implications, quality, safety

and patient experience, risks and assurance, Well-being of Future Generations, Health and Care Quality Standards (Duty of Quality) and workforce;
- the Service Level Agreements in place with NHS Wales organisations set out the operational arrangements for NWSSP's Services to them and are reviewed on an annual basis; and
- the responsibilities of Directors are reviewed at annual Performance and Development Reviews (PADRs).

5.2 Policies and Procedures

NWSSP follows the policies and procedures of the Trust as the host organisation. In addition, a number of workforce policies have been developed and promulgated on a consistent all-Wales basis through the Welsh Partnership Forum and these apply to all staff within NWSSP.

All staff are aware of and have access to the internal intranet where the policies and procedures are available. In a number of instances supplementary guidance has been provided. The Trust ensures that NWSSP has access to all the Trust's policies and procedures. NWSSP participates in the development and revision of workforce policies and has established procedures for staff consultation.

The SSPC will, where appropriate, develop its own protocols or supplement policies if applicable to the business functions of NWSSP. The Managing Director and other designated officers of NWSSP are included on the SSPC Scheme of Delegation.

5.3 Information Governance

NWSSP has established arrangements for Information Governance to ensure that information is managed in line with the relevant ethical law and legislation, applicable regulations and takes guidance, when required from the Information Commissioner's Office (ICO). This includes established laws including Data Protection Legislation, Common Law Duty of Confidentiality, the Human Rights Act, the Caldicott Report, and specific Records Management Principles. The General Data Protection Regulations increased the responsibilities to ensure that the data that NWSSP collects, and its subsequent processing, is for compatible purposes, and it remains secure and confidential whilst in its custody.

The Director of Finance and Corporate Services is the designated Senior Information Risk Owner (SIRO) in relation to Information Governance for NWSSP. NWSSP has an Information Governance Manager who has the objective of facilitating the effective use of controls and mechanisms to ensure that staff comply with Information Governance fundamental principles and procedures. This work includes awareness by delivery of an online core skills training framework eLearning module on Information Governance, classroom-based training (when possible) for identified high risk staff groups, developing, and reviewing policies and protocols to safeguard information, and advising on and investigating Information Governance breaches reported on the Datix incident reporting system.

The Information Governance Manager is responsible for the continuing delivery of an enhanced culture of confidentiality. This includes the presence of a relevant section on the intranet and a dedicated contact point for any requests for advice, training, or work.

NWSSP has an Information Governance Steering Group (IGSG), chaired by the NWSSP SIRO, that comprises representatives from each directorate who undertake the role of Information Asset Administrators for NWSSP. The IGSG discusses quarterly issues such as GDPR and Data Protection Legislation, the Freedom of Information Act, Information Asset Ownership, Information Governance Breaches, Records Management, training compliance, new guidance documentation and training materials, areas of concern and latest new information and law. Matters for escalation are identified and reported to the SLG.

NWSSP has a suite of protocols and guidance documents used in training and awareness for all staff on the importance of confidentiality and to ensure that all areas are accounted for. These include email and password good practice guides, summarised protocols, and general guidance for staff. There is also a documented Privacy Impact Assessment (or "Privacy by Design") process in place to ensure consideration of Information Governance principles during the early stages of new projects, processes or work streams proposing to use identifiable information in some form.

Artificial Intelligence (AI) adoption including the use of Microsoft Copilot, is supported by clear organisational guidance to ensure ethical, secure and compliant use. Controls are in place to prevent inappropriate use of sensitive or commercially sensitive information, with staff accountability reinforced through existing IG and Information Security policies that enables innovation without weakening confidentiality. Guidance has been provided to staff, as well as access to the full AI policy.

NWSSP has developed an Integrated Impact Assessment process to include broader legislative and regulatory assurance requirements, and the pro-forma includes the need to consider the impact of the protected characteristics (including race, gender, and religion) on the various types of Information Governance protocols.

The Data Use and Access Act (DUAA) 2025 has been reviewed, and small changes were made to NWSSP's current controls to include Data Subject Access and the inclusion of a Data Protection Complaints protocol. The DUAA provides opportunities to simplify and clarify practice while continuing to protect individual rights which are also accompanied with the relevant guidance.The Information Governance Manager works closely with the Trust Data Protection Officer as the Head of Information Governance within the Trust and also attends various meetings including the NHS Wales Information Governance Management Advisory Group (IGMAG) hosted by Digital Health and Care Wales (DHCW) which is attended by all NHS Wales Health Bodies.

5.4 Health and Safety

NWSSP places the highest priority on the health, safety and welfare of its staff, service users, visitors and contractors. Achieving a positive health and safety culture is recognised as a shared responsibility, requiring active engagement and collaboration between management and staff at all levels of NWSSP.

NWSSP's aim is to provide and maintain a safe and healthy environment for all that use our services. A health and safety strategic improvement plan is in place which provides NWSSP with a framework for health and safety governance and assurance. In addition, a set of objectives provides an additional framework to deliver health and safety within NWSSP.

Strategic leadership and accountability for health and safety are provided by the Director of Finance and Corporate Services, supported by the NWSSP Health and Safety Manager and the team. Overseeing continuous improvement through performance monitoring, review of systems and processes, and structured governance arrangements, including regular discussions at the NWSSP All Wales Health and Safety Group. The Health and Safety Manager is a member of the Velindre NHS Trust Health and Safety Group and liaises closely with Velindre NHS Trust Health and Safety Manager in order to ensure that the Trust is aware of health and safety risks in NWSSP.

A comprehensive report of all incidents and activity is provided to the SLG at the end of each quarter and an annual report is reported to the SLG and SSPC.

There were 84 health and safety incidents reported for 2025-26 (compared with 72 in 2024-25). Long-term trend analysis indicates an overall downward trajectory over time. Continued progress against seven health and safety objectives, with targeted improvement activity aligned to the Health and Safety Strategic Improvement Plan. There were 10 Reporting of Injuries, Diseases and Dangerous Occurrences and Regulations (RIDDOR) reportable incidents (compared with 8 in 2024-25), which primarily related to manual handling. No enforcement action from the Health and Safety Executive or Environmental Health was taken. One new personal injury claim was received during the year (compared with 3 in 2024-25).

Health and safety incident reporting across NWSSP shows a sustained downward trend, with incidents reducing significantly from pre-2021 levels and remaining comparatively low in most service areas. Procurement Services, while historically the largest contributor, has shown a continued reduction in incidents, indicating improving control maturity and risk management. Higher incident levels are consistently reported within Health Courier Services and Laundry Services, reflecting the inherently higher operational risks associated with transport, logistics and operational environments and this remains an area of focus for the SLG. Other service areas report low or negligible incident levels, broadly aligned to their respective risk exposure.

Overall, this provides reasonable assurance that control arrangements are effective and have strengthened over time, although recent increases in some areas require continued management focus through the Health and Safety Strategic Improvement Plan. During the period, a schedule of health and safety internal audits were undertaken by the Health and Safety Manager and Health and Safety Support Officer using the Health and Safety Management System Framework (HSG65). Of 12 HSG65 assessments completed, 58% received Substantial Assurance and 42% received Reasonable Assurance; no sites were rated Limited or No Assurance.

Key areas requiring continued focus into 2026/27 include: contact with or struck by an object, noting an increase in incidents and reduction target not achieved this year and manual handling, noting a slight increase during 2025–2026 with further training, audits, ergonomic reviews and equipment/systems of work scheduled. An increase in the reporting of violence and aggression is reflective of a positive reporting culture but there will remain continued emphasis on prevention and post-incident support.

5.5 Internal Audit

The NWSSP Hosting Agreement provides that the SSPC will be subject to an effective independent internal audit as a key source of its internal assurance arrangements, in accordance with the Global Internal Auditing Standards and any other requirements determined by the Welsh Government.

Accordingly, for NWSSP, an internal audit plan has been approved by the Audit Committee which provides coverage across NWSSP functions and processes sufficient to assure the Managing Director of NWSSP and in turn the SSPC and the Trust as host organisation on the framework of internal control operating within NWSSP.

The delivery of the internal audit plan for NWSSP culminates in the provision of a Head of Internal Audit opinion on the governance, risk and control processes operating within NWSSP. The opinion forms a key source of assurance for the Managing Director when reporting to the SSPC, the Trust as host, and partner organisations.

5.6 Duty of Quality

During the year, work around embedding the Duty of Quality (DoQ) continued across NWSSP. We have focussed on ensuring that quality assurance is integrated into existing mechanisms, such as the IMTP for 2026-29, and as per the measures detailed in the Quality Assurance section above. NWSSP's third Annual Report on Duty of Quality for the 2025-26 period sets out the key achievements against the Health and Care Quality Standards, including:

- Quality planning and decision making;
- Quality management systems;
- Quality driven reporting;

- Quality driven reporting into Health Boards and Trusts;
- Quality control and using data for quality improvement;
- External quality reviews, accreditations and awards; and
- Staff voices.

6. PLANNING ARRANGEMENTS

The Integrated Medium-Term Plan (the Plan) is approved by the SSPC and performance against the plan is monitored throughout the year. The 2025-2028 plan was submitted to Welsh Government in accordance with required timescales, and the submission of the current 2026-2029 plan has similarly met the required Welsh Government deadlines.

Significant work has been undertaken to revise the performance framework to ensure that it is fully integrated with the key priorities in the plan. The majority of performance targets for 2025-26 were achieved and progress against each of these is reported to the SLG and the SSPC. There is also regular reporting to Welsh Government requirement on progress against the plan quarterly and also through bi-annual Joint Executive Team (JET) meetings.

The planning process includes substantial engagement with key stakeholders, both internally and across NHS Wales and the wider public sector, in both virtual team events and on a one-to-one basis.

The IMTP was submitted to the NHS Wales Chief Executive and Welsh Government before 31 March 2026 and there were no significant amendments to the Plan following the approval of the Committee earlier at its January 2026 meeting and the subsequent touchpoint meetings held with Welsh Government and the Finance Delivery Unit prior to submitting the Plan.

7. DISCLOSURE STATEMENTS

7.1 Equality, Diversity and Human Rights

NWSSP is committed to eliminating discrimination, valuing diversity, and promoting inclusion and equality of opportunity in everything it does. NWSSP's priority is to develop a culture that values each person for the contribution they can make to the services provided for NHS Wales. As a non-statutory hosted organisation within the Trust, NWSSP is required to adhere to the Trust Equality and Diversity Policy, Strategic Equality Plan and Objectives, which set out the Trust's commitment and legislative requirements to promote inclusion. NWSSP continues to ensure compliance with its legislative duties and aligns its activity with actions set out in its Inclusive Culture Action Plan.

NWSSP is a core participant of the NHS Wales Equality Leadership Group (ELG), who work in partnership with colleagues across NHS Wales and the wider public sector, to collaborate on events, facilitate workshops, deliver, and undertake training sessions, issue communications and articles relating

to equality, diversity, and inclusion, together with the promotion of dignity and respect for all.

We host a range of staff networks, and we continue to develop our inclusion offering for our workforce. This has included the introduction of Equality, Diversity and Inclusion training across divisions, alongside bespoke training to support education on discrimination, cultural awareness and inclusive behaviours. NWSSP also launched the Safe Inclusivity Campaign, creating opportunities for staff to ask questions in a safe, judgement-free environment, with questions used to further educate colleagues across the organisation.

NWSSP developed an Inclusive Culture Action Plan for 2025–2027, bringing together actions from across the organisation and reflecting Welsh Government requirements. One year into delivery, progress has been made through initiatives including 'Supporting You' roadshows, leadership development with targeted opportunities for under-represented groups, revised appraisal arrangements, the introduction of Compassionate Cultures and Speaking Up Safely training, and the implementation of the Work in Confidence platform. Delivery of the plan continues, with a clear commitment to transparency and ongoing engagement with staff to support positive cultural change.

In the spirit of continuous improvement, NWSSP are members of the Employers Network for Equality and Inclusion (ENEI), which supports organisations in their equality and inclusion journey. Based on the Anti-Racist Wales Action Plan, NWSSP developed a specific plan to address the actions that tie into the NWSSP Inclusive Culture Action Plan.

In 2026, the Welsh Government integrated the Workforce Race Equality Standard (WRES) into a single intersectional Workforce Equality Standard (WES), considering all aspects of identity including representation, recruitment and development. NWSSP will use this data, when available, to inform development of its Strategic Equality Plan and define targeted actions for improvement, where required. NWSSP's LGBTQ+ Wales Action Plan continues to link directly to the organisation's Diversity and Inclusion Action Plan. We have also introduced dedicated Diversity and Inclusion Ambassadors to support the creation of a positive and equitable working environment.

The development of the Equality, Diversity and Inclusion Group (EDI Group) was a result of the 'This is Our NWSSP' culture programme, where staff recognised the need for the organisation to prioritise the equality agenda and support employees. The EDI Group continues to support delivery of inclusive culture activity across NWSSP, working alongside Diversity and Inclusion Ambassadors and other key networks.

The process for undertaking Equality Integrated Impact Assessments (EQIIA) has matured, and considers the needs of the protected characteristics identified under the Equality Act 2010, the Public Sector Equality Duty in Wales and the Human Rights Act 1998, whilst recognising

the potential impacts from key enablers such as Well-being of Future Generations (Wales) Act 2015, incorporating Socio-Economic Duty, Environmental Sustainability, Modern Slavery Act 2015 incorporating Ethical Employment in Supply Chains Code of Practice 2017, Welsh Language, Information Governance and Health and Safety. More recently, the Duty of Quality has been embedded within the well-established process.

The Socio-Economic Duty placed a legal responsibility on NHS bodies when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. This duty remains a key consideration within NWSSP's strategic planning and decision-making.

Personal data in relation to equality and diversity is captured on the Electronic Staff Record (ESR) system and staff are responsible for updating their own personal records using the Electronic Staff Record Self-Service. This includes ethnicity, nationality, country of birth, religious belief, sexual orientation, and Welsh language competencies. Equality data continues to play an important role in understanding organisational culture, supported by the development of a new Equality, Diversity and Inclusion Dashboard to inform senior leadership decision-making. NWSSP continues to build trust with employees by being transparent about why equality data is collected and how it is used. The All-Wales Recruitment Service, run by NWSSP, adheres to practices and principles in accordance with the Equality Act and quality-checks adverts and supporting information to ensure no discriminatory elements are present.

NWSSP has a Core Skills Training Framework (CSTF) for its workforce, including the NHS Wales "Treat Me Fairly" e-learning module, which forms part of a national training package and the statistical data captured for NWSSP completion contributes to the overall figure for NHS Wales. A Core Skills for Managers Training Programme is provided, with the Managing Conflict module incorporating dignity and respect at work. Equality, Diversity and Inclusion training has been further embedded across divisions, complementing national mandatory training requirements.

Further, to support the Anti-Racist Wales Action Plan (ArWAP), Welsh Government mandated the completion of the accompanying training module for all NHS staff, including those who do not directly interact with patients or service users (*WHC 2024/044*) which NWSSP is enforcing for its staff.

7.2 Welsh Language

NWSSP continues its commitment to ensure the Welsh and English languages are treated equally in the services provided to the public and NHS partner organisations in Wales. This is in accordance with the Welsh Language Measure (Wales) 2011 and the Welsh Language Standards [No7.] Regulations 2018.

The work of NWSSP in relation to Welsh language delivery and performance is reported to the Welsh Government and the Welsh Language Commissioner within the Welsh Language Annual Performance Report.

Work is largely driven by the Head of Welsh Language Services and Compliance, who reports to the Director of People and Organisational Development. The Head of Welsh Language Services and Compliance works closely with the Managing Director, Senior Leadership Group and all divisions and services across NWSSP.

A Welsh Language Unit has been established to support our divisions and services with translation and interpretation services as well as providing advice and guidance on how best to plan service provision through the medium of Welsh.

For audit and compliance purposes, we have established a self-assessment process to monitor our compliance status with the Welsh Language Standards and Code of Practice and to measure our ability to provide Welsh language services that are equal to English language services. This process is bi-annual where the assessment is undertaken in year 1 followed by the development of local improvement plans, followed by the implementation of the improvement plan in year 2. This process assists us to provide assurance and accurate information about our compliance levels. Our overall compliance status as at the end of March 2026 was as follows:

Standards	**Level of compliance**
Service Delivery Standards	Medium to High Level of Compliance
Policy Making Standards	Medium to High Level of Compliance
Operational Standards	Medium to High Level of Compliance
Record Keeping Standards	High Level of Compliance
Supplementary Standards (*whereby the Commissioner will request additional information when required)*	High Level of Compliance

During 2025/26 NWSSP has reviewed the process of how scheduled procurement contracts can be assessed to include Welsh language service and delivery requirements in the specification of the Invitation to Tender Documents as well as an assessment tool to establish whether the Tender Documents need to be published in Welsh.

NWSSP has been developing a new Internal Use of the Welsh Language Policy during 2025/26 to strengthen compliance to the high level category in 2026/27, on the use of the Welsh language internally. This is following seminars and conferences attended with the Welsh Language Commissioner.

The Welsh Language Impact Assessment as part of the Equality Integrated Impact Assessment (EqIIA) was reviewed and improved in 2025/26, and as a consequence the assessments are more meaningful and robust in our

considerations of the Welsh language beyond the practice of translating. Consideration of persons, individuals and delivery of services are impacted by the Welsh language in NWSSP's decision-making processes go beyond the requirements of translation alone. NWSSP makes well informed decisions based on facts and key strategies and not on assumptions and opinions.

During 2025/26, 14 Welsh Language Impact Assessments were undertaken.

7.3 Handling Complaints and Concerns

NWSSP is committed to the delivery of high-quality services to its partners. The NWSSP Concerns and Complaints Management Protocol is reviewed annually. The Protocol aligns with the Velindre University NHS Trust Handling Concerns Policy, the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and Putting Things Right Guidance.

During 2025-26, 38 concerns were formally raised with NWSSP through the Protocol, of which:

- 35 were Formal Complaints received, whereby 100% of complaints were responded to within 30 working days; and
- 3 were Early Resolution Concerns received, where matters were able to be resolved within 48 hours, to the complainant's satisfaction. This represents a significant reduction compared to the previous year. However, NWSSP Corporate Services remain reliant on Services notifying them of matters resolved through this mechanism. Services have therefore been reminded of the importance of reporting all complaints resolved at an early stage to enable appropriate oversight and accurate reporting.

The total number of formal complaints received represents a significant and continuing decrease on the total for previous years (100 in 2021-22; 68 in 2022-23, 46 in 2023-24, 55 in 2024-25).

A thematic review of concerns and complaints received during the reporting period identified a small number of consistent, overarching themes. Complaints were primarily driven by communication issues, timeliness and delays, and the consistent application of processes, with a proportion of concerns relating to matters outside the remit of NWSSP and therefore requiring signposting to other organisations. During the year, there was a notable increase in concerns received for the Medical Examiner Service and Primary Care functions, primarily relating to delays in the issuing of Medical Certificates of Cause of Death, cross-border transfer of medical records, and processing of payments or prescriptions. The SLG receives regular reports on concerns and complaints at each meeting, enabling appropriate scrutiny, oversight, and timely management action. This structured approach provides assurance that emerging themes are identified,

addressed, and used to inform service improvements and strengthen operational performance.

7.4 Freedom of Information Requests

The Freedom of Information Act (FOIA) 2000 gives the UK public the right of access to a variety of information held by public bodies and provides commitment to greater openness and transparency in the public sector, especially for those who are accountable for decisions made on behalf of patients and service users.

There were 166 requests received within NWSSP during 2025-26, 97% of which were responded to within the 20-day deadline for compliance. This represents an increase, with 138 requests received in 2024/25, 98% of which were responded to within the 20-day deadline.

7.5 Data Security and Governance

In 2025-26 there were 41 (compared to 33 in 2024-25) reported information governance breaches reported within NWSSP; these included issues with mis-sending of email and records management. The majority of these were down to human error and despite education effectively provided to ensure awareness of confidentiality and effective breach reporting, unfortunately errors can happen.

All breaches are recorded in the Datix risk management software and investigated in accordance with the Information Governance and Confidentiality Breach Reporting protocols, which comply with the General Data Protection Regulation (GDPR). The protocols encourage staff to report those breaches that originate outside the organisation for recording purposes and the need to report is re-enforced by training provided by the Information Governance Manager.

From this, the Information Governance Manager writes quarterly reports including relevant recommendations and any areas for improvement to minimise the possibility of further breaches. Members of the Information Governance Steering Group are required to report on any incidents in their areas to include lessons learned and any changes that have been made since an incident was reported. The Information Governance Manager also provides quarterly reports to the Trust Data Protection Officer for assurance and provides performance information which forms part of the performance reporting to the Quality, Safety and Performance Committee.

There were two Information Governance breaches referred to the Information Commissioner's Office (ICO) for further investigation, but the ICO was content to close both cases with no further action being taken.

7.6 Business Continuity Planning and Emergency Preparedness

NWSSP has received confirmation from the NHS Performance and Improvement Team via Welsh Government that the organisation does not, by definition, come under the Civil Contingencies Act 2004 (CCA). However,

NWSSP have been directed to align with the duties of the Act and the NHS Wales Emergency Planning Core Guidance, to ensure that the organisation identifies and mitigates risks, has plans in place to respond to risks and shares information with relevant partners.

Departments within NWSSP are actively reviewing business impacts and putting plans in place to ensure that the organisation can continue to deliver products or services at acceptable predefined levels following a disruptive incident.

NWSSP is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify, assess, and implement applicable legislation and regulation requirements related to the continuity of operations and the interests of key stakeholders.

As a hosted organisation, NWSSP is required to take note of the Trust's Business Continuity Management Policy, supported by local guidance, in order to ensure that NWSSP has effective strategies in place for:

- People – the loss of personnel due to sickness or pandemic;
- Premises – denial of access to normal places of work;
- Information Management and Technology and communications/ICT equipment issues;
- Suppliers, internal and external to the organisation; and
- In addition, all Divisions have now been required to extend their Business Impact Assessments to identify department specific business continuity risk, and to plan and mitigate for them.

NWSSP has embarked on a programme of work to align to the International Standard for Security and Resilience — Business Continuity Management Systems (ISO 22301).

NWSSP has a network of Business Continuity Planning (BCP) Champions who meet bi-monthly with representatives from all Divisions. The Group is chaired by the Director of Planning, Performance, and Informatics.

NWSSP complete the Welsh Government Health Emergency Planning Report annually, on a calendar year basis. This provides assurance that measures are in place within NWSSP to manage and respond to major disruptive incidents and reaffirms the robust arrangements in place within the Supply Chain, Logistics and Transport Division, who are well versed in this area.

Previous reporting highlighted the need to ensure that all Divisions and relevant individuals within NWSSP were appropriately trained, communicated with, and engaged with key external stakeholders, where appropriate. A full training programme is in place to provide the following courses, which are delivered by the newly appointed Head of Emergency Planning Resilience and Response (EPRR):

- Business Continuity Planning for Managers;
- Major Incident Management;

- Major Incident and Business Continuity Loggist course; and
- Departmental Exercises.

In addition, in 2026-27, NWSSP will deliver a new Incident and Exercise Debriefing Course, to ensure that lessons learned from incidents are appropriately collated and actioned from business continuity incidents and exercises.

Full engagement with external stakeholders is achieved by the Head of EPRR and other designated staff attending a variety of Welsh Health Emergency Planning Forums and Groups, including NHS Executive Emergency Planning Advisory Group, Health, Social Care and Early Years System Resilience Group, and NHS Performance and Improvement. Attendance at the groups ensures NWSSP is fully integrated into the Welsh Health Resilience Frameworks.

The most recent Internal Audit Report on Business Continuity achieved Reasonable Assurance and contained a range of helpful key findings. Commencement of actions to address these key findings has resulted in the following developments:

- The appointment of a shared resource across the Planning Performance and Informatics department to enhance the administration and programme management of business continuity and emergency planning between departments.
- Departments have been utilising guidance on departmental Business Impact Assessment and Business Continuity Plan development; whilst also adapting the process to suit specialist departments to ensure risk identification, mitigation and plan development.
- An organisation wide document management system is still under review and is intended to be in place by the end of 2026. In the meantime, functions within Teams are being used to maintain BCM documentation.
- The Emergency Planning Resilience and Response Team have been working with the Audit Division within NWSSP to create an ISO 22301 Compliance Review process. The programme of compliance reviews will start in May 2026 reviewing each department, providing support and guidance to managers to enable full compliance with ISO 22301.

- meantime, functions within Teams are being used to maintain BCM documentation.
- The Emergency Planning Resilience and Response Team have been working with the Audit Division within NWSSP to create an ISO 22301 Compliance Review process. The programme of compliance reviews will start in May 2026 reviewing each department, providing support and guidance to managers to enable full compliance with ISO 22301.

7.7 Cyber Security

Through 2025-26, NWSSP has continued to mature its cyber security and resilience arrangements, moving from framework adoption to formal assurance and continuous improvement. An independent assessment against the Cyber Assessment Framework (CAF) was completed by the NHS

Wales Cyber Resilience Unit, providing a structured view of NWSSP's cyber resilience across governance, protection, detection, response and recovery.

The assessment confirmed that NWSSP has established many of the foundational capabilities expected of an organisation delivering critical services, with clear accountability, defined roles, and a risk based approach to cyber security governance. A small number of CAF outcomes were assessed as partially achieved, reflecting known areas for further work to strengthen arrangements. These findings, together with those reported by Internal Audit are understood and have been incorporated into a prioritised improvement roadmap.

Cyber security activity is now embedded within a broader approach to infrastructure and service resilience. NWSSP has participated in the NHS Wales Infrastructure Adoption Model (INFRAM) assessment, which provides a benchmarked view of cyber security maturity alongside infrastructure performance, availability and recoverability. This has reinforced the importance of cyber resilience as an enabler of reliable, safe and sustainable digital services.

Progress against cyber security improvement plans is monitored through defined performance indicators and reported regularly to the Senior Leadership Group, with the reporting having developed during the year and is still maturing. Where full compliance is not yet achievable, proportionate technical and procedural mitigations are in place and subject to routine review.

NWSSP continues to place strong emphasis on organisational readiness and staff awareness. Regular phishing simulations, targeted communications and senior level cyber incident exercises are used to strengthen preparedness and decision making. NWSSP also maintains active engagement with national NHS Wales cyber security forums to ensure alignment with system wide standards and emerging threats.

Taken together, these arrangements provide the assurance that cyber security risks are identified, understood and recommendations to help strengthen controls are acted upon promptly, and that NWSSP is continuing to test, strengthen and obtain assurance on its ability to prevent, detect, respond to and recover from cyber incidents that could impact the delivery of essential services.

7.8 UK Corporate Governance Code

NWSSP operates within the scope of the Trust governance arrangements. NWSSP is clear that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code.

7.9 NHS Pension Scheme

As NWSSP administers the payroll function for NHS Wales, there are robust control measures in place to ensure that all employer obligations contained within the Scheme regulations for staff entitled to membership of the NHS Pension Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

8. MANAGING DIRECTOR'S OVERALL REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the Directors and Heads of Service within NWSSP who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

Additionally, I have overall responsibility for risk management and report to the SSPC regarding the effectiveness of risk management across NWSSP. My advice to the SSPC is informed by reports on internal controls received from all its committees and in particular the Audit Committee.

Each of the Committees have considered a range of reports relating to their areas of business during the last year, which have included a comprehensive range of internal and external audit reports and reports on professional standards from other regulatory bodies. The Committees have also considered and advised on areas for local and national strategic developments and a potential expansion of the services provided by NWSSP.

8.1 Internal Audit Opinion

Internal Audit provide me and the SSPC through the Audit Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with Public Sector Internal Audit Standards by the Audit and Assurance function within NWSSP.

The scope of this work is agreed with the Audit Committee and is focussed on significant risk areas and local improvement priorities. The overall opinion of the Head of Internal Audit on governance, risk management and control is a function of this risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal

Audit has considered the impact of the audits that have not been fully completed.

The Head of Internal Audit opinion for 2025-26 was that the Shared Services Partnership Committee can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively:

Reasonable assurance		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. **Low to moderate impact** on residual risk exposure until resolved.

In reaching this overarching opinion the Head of Internal Audit has identified that the assurance domains relevant to NWSSP have all been assessed as providing reasonable assurance. During the year, there was one internal audit report issued with a rating of limited assurance in respect of cyber security governance arrangements. There were zero reports with no assurance. All other reports were either substantial or reasonable assurance, or were issued as advisory reports.

Cyber security assurance arrangements are reviewed by Internal Audit on a cyclical basis, with each review having a different area of focus. In 2025-26 the scope of the review primarily covered the development of governance arrangements including action planning, reporting and risk assessment processes. Internal Audit reported that further work is required to strengthen these arrangements and ensure consistency across the whole of NWSSP. The findings are welcomed to support improvement and a number of agreed actions have already been implemented and a follow up audit review is planned for 2026-27 to ensure that the actions are fully embedded.

8.2 Financial Control

NWSSP was established by Welsh Government to provide a range of support services to the NHS in Wales. As Managing Director and Accountable Officer, I retain overall accountability in relation to the financial management of NWSSP and report to the Chair of the SSPC.

8.2.1 NWSSP Financial Control Overview

There are four key elements to the Financial Control environment for NWSSP as follows:

- **Governance Procedures** – As a hosted organisation, NWSSP operates under the Governance Framework of the Trust. These procedures include the Standing Orders for the regulation of proceedings and business. The statutory requirements have been translated into day-to-day operating practice, and, together with the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions (SFIs), provide the regulatory framework for the business conduct of the Trust. These arrangements are supported by detailed financial operating procedures covering the whole of the Trust and also local procedures specific to NWSSP.

- **Budgets and Plan Objectives** – Clarity is provided to operational functions through approved objectives and annual budgets. Performance is measured against these during the year.

- **Service Level Agreements (SLAs) –** NWSSP has SLAs in place with all customer organisations and with certain key suppliers and other NHS organisations. This ensures clarity of expectations in terms of service delivery, mutual obligations, and an understanding of the key performance indicators. Annual review of the SLAs ensures that they remain current and take account of service developments.

- **Reporting** – NWSSP has a broad range of financial and performance reports in place to ensure that the effectiveness of service provision and associated controls can be monitored, and remedial action taken as and when required.

Through this structure NWSSP has maintained effective financial control which has been reviewed and accepted as appropriate by both the Internal and External Auditors.

9. CONCLUSION

This Governance Statement indicates that NWSSP has continued to make progress and mature as an organisation during 2025-26 and that it is further developing and embedding good governance and appropriate controls throughout the organisation. NWSSP has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads me to conclude that it has a robust system of control.

I confirm that I am aware of my ongoing responsibilities and accountabilities to ensure compliance in all areas as outlined in the above statements continues to be discharged for the financial year 2025-26.

Signed by:

Managing Director – NHS Wales Shared Services Partnership

Date: