Morriston Service Group Governance Arrangements

Final Internal Audit Report

2025/26

Swansea Bay University Health Board

Limited Assurance

Contents

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Fieldwork	March - April 2026
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Audit Committee	16 July 2026
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Executive Summary

Purpose

Review of the Morriston Service Group's (MSG) assurance framework and governance arrangements, including the management of risk, and to consider the effectiveness of arrangements for planning and performance, quality and safety, and workforce. The review also considers the effectiveness of divisional governance, with specific reference to the Specialist Surgical Services Group (SSSG).

Overview

Swansea Bay University Health board (the health board) is structured into four Service Groups (SG), each led by a triumvirate leadership team made up of an Operations Director, Nurse Director and Medical Director. The Acute Medical Services Redesign (AMSR) programme was designed to develop centres of excellence and reduce duplication across Morriston, Singleton and Neath Port Talbot hospitals. Key elements of the programme included the centralisation of acute medical admissions at Morriston hospital, the opening of a new Acute Medical Unit with integrated Same Day Emergency Care facilities, and the expansion of a medical ward base. A separate review of the AMSR programme's benefits realisation was undertaken as part of the 2024/25 Internal Audit plan and received a Reasonable Assurance rating.

An Audit Wales review published in September 2024 considered governance arrangements across all four SGs. It concluded that, "*operational governance arrangements in the Health Board's service groups need strengthening. Action is needed to address long standing vacancies and reliance on interim roles, and to strengthen escalation arrangements, quality and safety reporting, and risk management*". While we note that some of the actions arising from this review remain outstanding, the health board's audit tracker reflects progress updates for those that are overdue.

We undertake an annual review of governance arrangements, rotating focus across each SG. Previous audits of the Mental Health and Learning Disabilities SG, and the Neath Port Talbot & Singleton SG, identified recurring themes consistent with those highlighted by Audit Wales. There remains an opportunity to strengthen cross-organisational learning to enable SGs to proactively identify and address common governance gaps. A comparison of themes identified across SGs is set out in Appendix A.

During 2025/26, a number of new Executive Directors have taken up post, resulting in shifts in strategic focus and the implementation of more streamlined corporate reporting arrangements. Increased emphasis has been placed on recovery and sustainability, with corresponding changes applied at SG level. A key recommendation from the Audit Wales' review and our previous rotational audits, to strengthen reporting from SGs to Executive Directors, has been addressed through the implementation of regular performance review meetings. It is anticipated that planned revisions to the Performance and Accountability Framework will further improve accountability for performance, finance and quality.

The 'Organised for Success' programme presents an opportunity to further enhance governance structures, as the health board transitions from four SGs to six care groups, aligning delivery more closely with Welsh Government (WG) priorities. Roles, functions, responsibilities and governance arrangements are currently under development.

MSG continues to face significant challenges in delivering unscheduled care and managing patient flow through the acute hospital system. We recognise that MSG has been led by an interim director since November 2025.

We have provided a **limited assurance** opinion. MSG's governance arrangements are not aligned with those operating in other SGs, and weaknesses in the current framework limit effective oversight of workforce, performance, annual planning, quality and safety, and risk management. The matters requiring management attention include:

- The MSG governance structure requires strengthening. The MSG Management Board has not met since May 2025, and there is no formal reporting mechanism for reporting health board priorities or other key updates. In the absence of a functioning Management Board, the Senior Leadership Team is intended to function as the key decision-making forum; however, this is an informal forum – key decisions, approvals and escalations are not consistently documented. Further, a number of recent meetings were cancelled due to operational pressures.

- The terms of reference for key governance groups within MSG need to be enhanced, and their approvals require evidencing. While meetings are generally well administered, effectiveness could be improved through putting in place forward work programmes and the routine submission of written divisional reports.
- More robust arrangements are required to prompt the timely reviews of policies and procedures, and to improve the management and monitoring of declarations of interest.

To avoid duplication, aspects of budget setting, annual plan delivery and risk management were excluded from scope, as these areas have been subject to recent audit review. Full details of findings and agreed management actions are set out in the Findings & Agreed Action Plan.

Scope & Assurance Summary

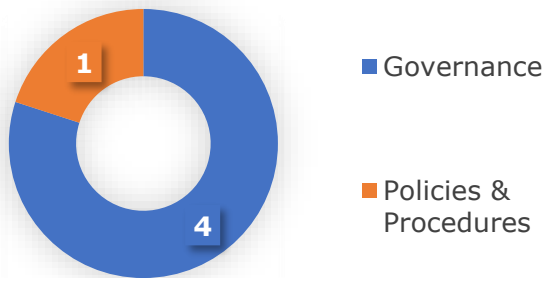
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Service Group has a clearly defined organisational structure, supported by approved terms of reference and work programmes.	1, 2, 3	**Limited**
2	The Service Group's terms of reference and work programmes are aligned with its key objectives and the overarching priorities of the health board.	1, 2, 4, 5	**Limited**
3	Specialist Surgical Services Group divisional arrangements effectively support the Service Group's delivery of key objectives and operate in accordance with defined terms of reference and work programmes.	1, 2, 3	**Reasonable**
4	The Service Group has appropriate mechanisms in place to provide oversight and assurance in relation to key risks and issues.	1, 2	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Service Group has a clearly defined organisational structure, supported by approved terms of reference and work programmes.	**Limited**

The leadership team of the MSG comprises a SG Director, Nurse Director, and Medical Director, supported by three Associate SG Directors (ASGDs). MSG has four operational divisional structures: Acute & Emergency Care and Hospital Operations (AECHO); Medical Specialities; Specialist Surgical Services Group (SSSG), including Pathology; and Integrated Surgical Services Group (ISSG), including Radiology.

Our previous SG governance reviews (see Appendix A) have noted that, as a minimum, SG governance frameworks typically include a Management Board, a Senior Leadership Team (SLT), and a Quality and Safety Group. MSG's governance structure includes a weekly SLT meeting, intended to provide operational oversight and responsiveness and supported by regular finance and business updates; a monthly Risk Management Group (RMG); and a monthly Quality, Safety and Patient Experience (QSPE) Group. The latter has a documented governance structure, supported by divisional QSPE groups, setting out the formal arrangements for quality and safety oversight.

MSG previously operated a quarterly Management Board, with responsibility for oversight of operational, quality, workforce and finance matters. However, this Board has not met since May 2025 (see **Key Finding 1**); with the preceding meeting having taken place in November 2024. Audit Wales highlighted a similar issue in its review of Operational Governance (September 2024). In contrast, other SGs operate Management Boards that meet on a monthly or bi-monthly basis.

In addition, other SGs have either dedicated groups to oversee specific areas (such as workforce) or a monthly performance meeting to monitor delivery of health board priorities. MSG does not have equivalent arrangements. Although the Specialist Surgical Services Group (SSSG) Divisional Management Board's terms of reference (ToR) referred to a quarterly divisional performance review this no longer takes place (see **Key Finding 1**).

The substantive SG Director left post in October 2025. An interim SG Director was appointed in November 2025, pending implementation of a new care group structure originally planned for April 2026. While gaps to the MSG governance framework were recognised, no substantive changes were implemented due to the anticipated short interim period. The implementation of the care group structure has since been delayed until September 2026.

ToRs were provided for all key groups with the exception of the MSG Management Board and SLT (see **Key Finding 2**). For QSPE and RMG, approval could be evidenced; however, only the RMG ToR was current (see **Key Finding 2**). Both ToRs contained key details relating to the group's purpose, membership, quorum, meeting frequency, and reporting arrangements; however, their content could be strengthened to define escalation routes and to evidence approval dates (see **Key Finding 2**).

We reviewed recent papers for the SLT (January–April 2026), RMG (September-December 2025) and QSPE (November 2025-February 2026) meetings. In the absence of a ToR for SLT (see **Key Finding 2**), we were unable to confirm formal arrangements such as quoracy and noted that a number of meetings had been cancelled due to operational pressures (see **Key Finding 1**). Generally, meetings were well administered, with written reports provided and limited reliance on verbal updates. However, work programmes were not always in place to assist with the effective forward planning (see **Key Finding 3**). We also noted gaps in Radiology reporting to RMG meetings (see **Key Finding 3**) - the Head of Quality and Safety (MSG) advised that this reflected uncertainty regarding reporting routes following divisional changes, but we were advised that the matter has since been resolved.

Key Findings		Risk & Impact	Agreed Management Action
1	**Gaps in Morriston Service Group (MSG) governance structure and formal oversight.** The MSG Management Board, which has delegated accountability from the Executive Team for key strategic and operational decisions relating to the SG, has not met since May 2025 (there is an action log but no corresponding minutes available). Prior to this the Board met in November 2024 confirming that meetings have not been held quarterly in line with the terms of reference. The effectiveness of the MSG governance framework has been adversely impacted and has resulted in key governance documentation not being updated to reflect current arrangements. For example, the MSG's Quality and Safety governance structure and associated terms of reference continue to record formal reporting lines to the MSG Management Board, which is no longer operating. Whilst not formally documented, in the absence of a functioning Management Board, the Senior Leadership Team (SLT) is intended to function as the key decision-making forum in the interim. However, the SLT does not have formal terms of reference to formally define its purpose, authority, membership, or escalation responsibilities. While SLT meetings are scheduled weekly, 6 of 14 planned meetings between January and April 2026 were cancelled due to operational pressures. Although meetings that did take place were supported by detailed meeting minutes and action logs, there was insufficient evidence of key decisions, approvals or escalations being formally recorded. Furthermore, the MSG governance structure does not include clear mechanism for providing routine oversight of progress against key health board priorities, other than Recovery and Sustainability, which is reported to SLT. While dedicated QSPE and RMG meetings are in place, there is no formalised onward reporting from these groups to SLT. SSSG's Divisional Management Board ToR refers to a quarterly divisional performance review; however, this does not currently exist within the MSG structure and there are no structured or routine updates to SLT covering workforce, annual planning or overall performance.	The absence of a clearly defined and consistently applied governance structure, supported by approved terms of reference and effective reporting arrangements, may weaken MSG's accountability for decision-making and limit assurance over the oversight of performance, quality and safety, workforce and risk. **High Priority**	**Agreed Action:** • Morriston Service Group (MSG) Management Board to be re-established from July 2026 with Board meetings to be held bi-monthly in support of established weekly/monthly governance meetings. • Review and refresh the weekly MSG Senior Leadership Team (SLT) and MSG Management Board terms of reference and operating arrangements. Terms of reference to include scope, membership, reporting requirements, relationship to MSG Board (SLT) and escalation routes (MSG Management Board); and will be appropriately approved. • Work programme to be developed for MSG Board setting out requirements for routine reporting on health board priorities, workforce issues, financial position, operational risks and quality & safety. To include reference to key governance review dates for all workstreams within the remit of the Management Board. • MSG standard agenda to be implemented and to include routine monitoring of the work programme and action log. • MSG Management Board and SLT attendance logs to be maintained as part of meeting outcomes notes. • MSG Management Board and SLT action logs to be maintained in support of meeting outcomes and to include clear action ownership, timescales and reporting requirements. **Expected Evidence of Implementation:** • SLT and MSG Management Board Terms of Reference and Operating Arrangements. • Meeting notes to confirm acceptance of SLT and MSG Management Board terms of reference. • SLT and MSG Management Board standard agendas (including work programmes), attendance and action logs. • Dedicated Teams document repositories for SLT and MSG Management Board including access to templates. **Officer:** Interim Group Service Director (Morriston) **Target Implementation Date:** 31 August 2026

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Governance	Control Operation	
2	**Terms of reference are not current or consistently approved.** Terms of reference (ToR) were provided for some key groups within the MSG's governance framework. However, weaknesses were identified that limit clarity of roles, responsibilities and accountability: • There is no current Management Board ToR reflecting the fact the Board has not met since May 2025. Although the ToR specifies that it should be reviewed annually, it was last approved in July 2024. • There is no approved SLT ToR setting out meeting purpose, authority or arrangements. Although a draft exists, it is no longer considered fit for purpose. • Evidence of expected annual review of ToRs was not available for the QSPE Group (last reviewed July 2024, with a next review date of March 2026); the Professional Advisory Group (last reviewed September 2024) and the SSSG Divisional Management Board (last reviewed August 2024). • The ToRs for SSSG Divisional Management Board and the Nursing Workforce Group do not detail quoracy arrangements. • The ToRs for the QSPE Group, RMG and SSSG's Divisional Management Board do not clearly define escalation arrangements. In addition, all ToRs reviewed could be enhanced by clearly recording the date of approval.	The absence of current, approved and consistently maintained terms of reference risks unclear roles and responsibilities, weakened accountability, and reduced assurance over the delivery of key priorities and effective governance.	**Agreed Action:** In conjunction with actions identified in response to Key Finding 1: • With reference to health board templates, implement standard document template used to support terms of reference and operating arrangements within the Morriston Service Group. Document to include specific reference to quoracy, version control and review dates. • Circulate agreed templates widely within the operational group with a request to ensure that Divisional templates and subsequent governance documents meet minimal expected standards and ensure consistency, compliance and clear routes of escalation. • Review and refresh terms of reference and operating arrangements and work programme in support of monthly Quality, Safety & Patient Experience meetings, in line with established review dates. • Review and refresh terms of reference and operating arrangements and work programme in support of monthly Group Risk Management meetings, in line with established review dates. **Expected Evidence of Implementation:** • Standardised templates for terms of reference and operating procedures, work programme, reporting, and agendas. • Email confirming sharing of standardised document templates with operational Divisions including action required and timescales for implementation. • Terms of reference and operating procedures for both the Group Quality, Safety & Patient Experience and Risk Management meetings. • Notes confirming review and approval of Quality, Safety & Patient Experience and Risk Management terms of reference and operating arrangements. • Dedicated Quality, Safety & Patient Experience Teams document repository, including section for standardised documents and reporting templates.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Interim Group Service Director (Morriston) **Target Implementation Date:** 31 July 2026
	Theme: Governance	Control Operation	
3	**MSG meeting administration requires strengthening.** With the exception of the RMG and the QSPE Group, formal work programmes are not in place for other key groups within the MSG governance structure, nor within the SSSG division. While the MSG Management Board is currently not meeting (see key finding 1), the absence of an agreed work programme does not align with expected governance standards and limits preparedness for when meetings resume. Our review of RMG papers covering the period September to December 2025 identified issues with attendance and reporting from Radiology. Meeting minutes from October 2025 record that they were unable to attend, which was also the case at the September meeting. The December 2025 minutes notes that the relevant item had again been deferred, until February 2026. No subsequent evidence was provided to demonstrate that Radiology reporting has since been reinstated in line with expectations. We also note an increased reliance on verbal updates rather than written reports at SSSG Divisional QSPE meetings. Review of agendas from October and November 2025, and January 2026, indicated that only 33% of agenda items were supported by written reports. This limits the ability to evidence oversight, challenge and follow-up of issues discussed.	The absence of clear work programmes and consistent reporting expectations may reduce the effectiveness of meetings, weaken accountability for actions and escalations, and limit assurance over oversight of key risks, quality and safety matters of issues escalated.	**Agreed Action:** Please see actions identified and set out in response to Key Findings 1 & 2. • Explicit work programme template to be included as part of standardised terms of reference and operating arrangement document pack. • Work programme template to include explicit timetable for reporting (written/verbal reporting) and agreed reporting frequency. **Expected Evidence of Implementation:** • Please refer documentation and evidence implementation detailed in Key Findings 1 & 2.
		Medium Priority	**Officer:** Interim Group Service Director (Morriston) **Target Implementation Date:** 31 July 2026
	Theme: Governance	Control Operation	

Objective 2: The Service Group's terms of reference and work programmes are aligned with its key objectives and the overarching priorities of the health board.	**Limited**

Planning & Performance

Our audit of Annual Plan Delivery (report issued April 2026: limited assurance) identified weaknesses across SGs in the processes for monitoring and reporting delivery of the Annual Plan. Unlike other SGs, MSG does not have a dedicated planning and performance lead. MSG has not maintained operational monitoring records to track progress against its Annual Plan delivery actions, which represent 147 of the health board's total 331 actions, and there is no formal internal reporting mechanism to monitor delivery.

While MSG performance is reported externally through the health board's monthly and quarterly SG level performance review process, there is no formal mechanism within the MSG governance structure for routine performance reporting or oversight (see **Key Finding 1**).

Quality and Safety

Divisional reporting to the QSPE Group is supported by standard templates, providing consistency on the information detailed for incidents, concerns and complaints, infection prevention and control, and quality priorities. However, despite the QSPE's ToR setting out formal reporting to the MSG Management Board, there is currently no effective forum providing formal MSG-level oversight of quality and safety matters beyond QSPE and divisional structures, due to the Management Board not meeting (see **Key Finding 1**).

Workforce

MSG reports progress against the health board's People Strategy through the health board's performance review arrangements. Divisional workforce reports provide workforce metrics including sickness absence, statutory and mandatory training compliance, and PADR completion. (see table below noting performance in line with the health board's target and actual position) through the MSG's divisional workforce reporting. However, there is no formal mechanism currently within the MSG's governance framework (see **Key Finding 1**) to routinely report workforce matters, as there is no scheduled reporting to SLT.

Instead, workforce exception reports are provided to MSG's triumvirate through informal meetings that are not minuted, limiting transparency and assurance over challenge, decision-making and follow-up actions:

Workforce Indicator	Sickness Absence	Statutory & Mandatory Training	PADR
MSG – March 2026	7.16%	85.95%	75.78%
MSG – December 2025	7.15%	86.05%	64.64%
Health Board – December 2025	7.17%	89.43%	73.73%
Health Board Target	5.50%	85.00%	85.00%

MSG has historically reported high levels of sickness absence. A Senior Workforce Efficiencies Improvement Lead was recruited to support improvement activity, though their remit was expanded in 2024 to incorporate wider workforce metrics. A Workforce Governance and Escalation Framework has since been developed, introducing defined escalation thresholds for sickness absence, PADR and training compliance, and supporting routine workforce audits. Outcomes are reported to the MSG triumvirate and SG Nursing Workforce Group. However, we noted the ToR for the SG Nursing Workforce Group and the Professional Advisory Group require strengthening (see **Key Finding 2**).

Finance

Our audit of Budget Setting (report issued March 2026: Reasonable Assurance) highlighted gaps in MSG's budget accountability processes, including the absence of formal divisional budget delegation arrangements and one unsigned Assistant Service Group Directors (ASGDs) accountability letter for 2025/26.

The MSG's Financial Strategy (May 2025) details that financial assurance is provided through the quarterly Management Board and quarterly divisional performance reviews. However, as noted in **Key Finding 1**, as the MSG Management Board is not operational and divisional performance reviews are not taking place, these assurance mechanisms are not functioning as intended. Regular financial updates are instead provided to SLT, focussing on the wider health board's recovery and sustainability as well as the SG's in-year financial position.

At month 12, MSG reported a £6.266m year-end overspend. Month 11 reporting to Performance and Committee (PFC) (March 2026) indicated a £5.3m overspend, with continued budgetary pressures within AECHO. While pathology vacancies have contributed to cost reductions, there remains reliance on variable pay to maintain services, particularly within radiology and pathology. Savings delivery reported a £6.4m shortfall against the £16.1m target, with a £10m recurrent savings shortfall forecast for the next financial year (2026/27).

Policies and Procedures

MSG policies and procedures are accessible to staff through the health board's Clinical Online Information Network (COIN), which includes a prompt to support timely review. MSG undertook a review of COIN content during August 2025 and highlighted issues relating to Local Safety Standards for Invasive Surgical Procedures (LocSSIPs), which are currently subject to a separate Internal Audit review. Our review of COIN also identified other procedures and guidance that appeared out-of-date (see **Key Finding 4**). The Head of Quality and Safety (MSG) advised this reflects COIN update issues rather than failures to review underlying policies.

Declarations of Interest

There is no robust mechanism in place for routine maintenance, review and assurance of registers of declarations of interest registers (see **Key Finding 5**).

Key Findings		Risk & Impact	Agreed Management Action
4	**Policies and procedures are not consistently reviewed or current.** MSG does not have a consistent mechanism in place to provide oversight and assurance that policies and procedures are reviewed and updated within their designated timeframe. Our review of COIN identified that 6 of 25 policies and procedures were not current. These included three relating to Pathology, and one each relating to Cardiac Services, Medicine and Surgery.	Inconsistent arrangements for the review and management of policies and procedures may result in outdated guidance being accessible to staff, leading to confusion, reduced compliance, and weakened	**Agreed Action:** • Morriston Service Group Task & Finish Group to be established to undertake a targeted review of applicable policies and procedures, recognising some may be health board specific. Scope to be confirmed. • Create an inventory of all procedures for which Morriston Service Group are responsible. • Implement a Group Standard Operating Procedure to support the management of the MSG procedure inventory, additions, deletions and updates, in line with revision dates. **Expected Evidence of Implementation:**

Key Findings		Risk & Impact	Agreed Management Action
		accountability and oversight.	• MSG Task & Finish Group scoping document setting out aims and objectives. • MSG Inventory of Procedures. • MSG Standard Operating Procedure to support the management of procedures. • Routine reporting/monitoring to be included within MSG Management Board work programme.
		Medium Priority	**Officer:** Interim Group Medical Director (Morriston)
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 31 December 2026
5	**Declarations of interest are not consistently recorded or reviewed.** Section 6.4 of the health board's Standards of Business Conduct Policy (the Policy) assigns responsibility to Service Group Directors for maintaining and reviewing registers of declarations of interest (DOI). We were advised that DOI returns for MSG Directors were completed as part of the health board's 2025/26 corporate process, but the SG does not retain copies of the completed declarations to support local assurance and ongoing oversight. There is currently no formal process to prompt for, and record or review DOIs for other relevant postholders, such as Associate SG Directors (ASGDs). These staff were not required to complete DOI forms as part of the 2025/26 corporate exercise, although they will be expected to do so in 2026/27. Section 18.2 of the Policy requires all consultants to complete a standard DOI and to declare when undertaking private practice. We were advised that this information is captured through the job planning process, but there was a lack of clarity regarding how the outcomes of these declarations are recorded, reviewed or formally shared within MSG.	Failure to consistently record and review declarations of interest may result in undisclosed conflicts of interest, which could compromise the health board's integrity, impartiality and transparency.	**Agreed Action:** • MSG Standard Operating Procedure to be developed and implemented setting out the requirements of the health board's Business Conduct Policy in relation to the submission of Declaration of Interest (DOI) statements by Group Consultant Staff, Group Directors and Divisional Triumvirate. • Compliance with the submission of DoI statements to be routinely included within Divisional workforce reporting. • Compliance with submission of DoI statements reporting to be included within MSG Management Board work programme. **Expected Evidence of Implementation:** • Email communication via operational Divisional structures requesting submission of DoI statements. • MSG Standard Operating Procedure for Business Conduct and Declaration of Interest. • Divisional workforce reporting including DoI compliance metrics. • MSG Management Board work programme to include routine reporting requirement of DoI compliance.
		Medium Priority	**Officer:** Interim Group Service Director (Morriston)
	Theme: Governance	Control Design	**Target Implementation Date:** 31 August 2026

Objective 3: Specialist Surgical Services Group (SSSG) divisional arrangements effectively support the Service Group's delivery of key objectives and operate in accordance with defined terms of reference and work programmes.	**Reasonable**

Our review focused on the SSSG division, which was established following the MSG restructure in 2024. We were provided with a structure setting out the key areas within the division: Burns and Plastic Surgery, Medical Illustration, Dermatology, Cardiac Services and Intensive Care. The division is led by the ASGD, who has been in post since August 2025, and is also responsible for ISSG, including Radiology and Pathology. The SSSG leadership team consists of a Divisional Manager, Head of Nursing and Medical Director. At the time of our review, there were four vacancies within the divisional structure: Deputy Heads of Nursing for Burns and Plastic Surgery, Intensive Care Unit, and Dermatology; and the Head of Medical Illustration.

The Division's governance framework encompasses a bi-monthly Divisional Management Board, with delegated authority from the MSG Management Board for oversight of performance, quality and safety, risks, finance and workforce, and a monthly Divisional QSPE meeting.

ToRs were in place for both groups and set out key elements including purpose, membership, meeting frequency, and reporting arrangements. However, the content of the ToRs could be strengthened to clearly articulate quoracy arrangements (Divisional Management Board) and escalation routes (Divisional Management Board and QSPE) (see **Key Finding 2**). The Divisional Management Board ToR was last reviewed in August 2024, outside of the annual review cycle, and has not yet been formally approved (see **Key Finding 2**). While the ToR was discussed at the March 2026 meeting, approval was deferred pending confirmation of quoracy arrangements, with further consideration planned for May 2026.

Overall, meetings were well attended, quorate, and administered appropriately. However, we noted the absence of agreed work programmes to support effective forward planning (see **Key Finding 3**). In addition, Divisional QSPE meetings relied on verbal updates rather than written reports, which limits the audit trail and assurance available (see **Key Finding 3**).

Planning & Performance

As highlighted under *Objective 2*, our Annual Plan Delivery audit identified weaknesses in SG-level monitoring and reporting arrangements. The Divisional Management Board ToR refers to a quarterly divisional performance review; however, this does not currently exist within the MSG structure (see **Key Finding 1**). Notwithstanding this, performance and quality and safety matters are reported through the Divisional Management Board and Divisional QSPE meetings.

Workforce

The Division reports workforce metrics, including sickness absence, statutory and mandatory training compliance and PADR completion (see table below noting performance in line with the health board's target) to the Divisional Management Board:

Workforce Indicator	Sickness Absence	Statutory & Mandatory Training	PADR
SSSG – February 2026	8.32%	85.80%	80%
Health Board Target	5.50%	85.00%	85%

We note that high sickness is primarily attributed to the small Dermatology team, with a high absence rate also noted within ITU; the latter also being an area flagged as requiring improvement in PADR compliance.

Finance

Schedule 6 of the Standing Financial Instructions requires budget holders to sign an accountability letter to formally delegate budgetary responsibility. The SSSG ASGD signed an accountability letter for the 2025/26 financial year.

Monthly meetings are held between the ASGD and the Finance Business Partner, and financial updates are reported to the Divisional Management Board. At the March 2026 meeting, SSSG reported a year-to-date overspend of £3.562 million, primarily attributable to pay pressures, including high bank and agency staff costs, and unfunded expenditure.

Objective 4: The Service Group has appropriate mechanisms in place to provide oversight and assurance in relation to key risks and issues.	**Reasonable**

Risk Oversight and Assurance

Our review of Risk Management & Assurance (report issued March 2026: Reasonable Assurance) identified a number of areas requiring improvement across the health board, including the need for more detailed procedures to provide clear guidance to staff involved in the management of risks, reduced assurance over the management of operational risks generally despite potential risks for escalation being reported to the health board's SG level performance reviews, and action plans should be put in place to address gaps in controls or assurances relating to Board-level risks. The review also reported the presence of long-standing risks within SGs that had not been substantively actioned for several years, alongside instances of risk scoring being set unnecessarily high.

MSG is currently undertaking a review of its risk register, with an initial focus on long-standing risks pre-dating 1 January 2019. Our analysis of the MSG risk register as at 31 March 2026 recorded 276 risks, including 30 relating to SSSG. The following issues were identified:

- 28 risks pre-dated 2019, with the earliest risk opened in September 2010 (risk 227: Surgery) but the risk had been reviewed on 15 December 2025.
- 8 risks did not detail controls in place (AECHO - risks 4216, 2652 and 2651; ISSG risks 3807, 3445 and 3415; Radiology risk 3227; and Medicine risk 3743).
- 50 risks did not detail any assurances in place.
- 267 risks did not have a target risk score date recorded; and
- 144 risks had review dates that had passed. While we acknowledge that some reviews may have taken place, the review date field had not been updated to evidence this).

We have not raised a recommendation in relation to these issues, as they were addressed within the Risk Management & Assurance audit, which also confirmed progress against actions from previous reviews, including the strengthening of arrangements to promote and monitor the consistency and completeness of operational risk registers. The latest update notes that operational risks will be considered by the new Operational Executive Group in 2026/27.

At a divisional level, monthly risk meetings are held and divisions report into the MSG RMG using a consistent template to highlight changes to risks, emerging issues and items requiring escalation. However, while the MSG RMG ToR specifies reporting to the MSG Management Board, this forum is not currently operational, and there is no formal oversight of risk matters through SLT (see **Key Finding 1**).

Reporting and Escalation

Both the internal audit reviews of NPTSSG and MHLDSG's governance arrangements and the Audit Wales Operational Governance review identified the absence of formal reporting lines from the SG Management Boards into the health board's Management Board. Audit Wales recommended that reporting templates be amended to incorporate explicit escalation prompts and that clear escalation thresholds and processes be agreed. While we note progress through the introduction of regular SG performance review meetings with Executive Directors, covering performance, risks, quality and safety, finance, digital and workforce matters, this has not fully addressed the original management action. As a result, the recommendation remains outstanding on the health board's audit recommendation tracker.

MSG provided evidence of monthly reporting submitted between September 2025 and March 2026, which includes a prompt for 'risks and decisions required'. However, we were not provided with associated meeting records to confirm whether escalations had occurred or the outcomes of any discussions. We acknowledge that the health board's Performance and Accountability Framework is currently being revised, with the intention of strengthening accountability for performance, finance, and quality, including routine escalation reporting from each SG; and it is anticipated that such will enhance arrangements further.

Routine MSG reporting is also provided to Board Committees, including every four months to PFC and periodic updates to the Workforce and Organisational Development (WOD) Committee. MSG reported to WOD in August 2025 on staff survey outcomes and sickness absence management and is due to report again in June 2026.

Historically, SGs reported quarterly to Quality and Safety Committee (QSC). The last MSG report to this Committee was in January 2025, with the most recent SG report overall (MHLD) presented in March 2025. We note that the Committee work programme is under review and that SG reporting arrangements changed during 2025/26. MSG now contributes to quality and safety assurance as required through submitting a report on alternate months to the Patient and Stakeholder Experience Group, the Patient Compliance Group, and also to Quality and Safety Group (from September 2025).

Within MSG, we have identified that a number of ToRs need to be enhanced to clearly define escalation arrangements (see **Key Finding 2**). Our review identified limited evidence of formal escalation of risks outside of the RMG.

Appendix A: Analysis of themes arising from Service Group Governance reviews

The table below summarises key recurring themes arising from our audits of SG Governance arrangements, together with SG-specific issues identified through recent Risk Management & Assurance, Budget Setting and Annual Plan Delivery audit reports. The analysis highlights areas of common weakness as well as good practice across Service Groups.

This comparative analysis is intended to support organisational learning and to inform the design and implementation of appropriate governance arrangements within the emerging Care Group model.

***Note**: A full SG Governance review of the Primary, Community and Therapies SG has not yet been undertaken. However, issues relevant to this SG identified through other audit work are included where applicable.*

Service Group	Themes/ Key Findings Arising							
	SG Structure	**Terms of Reference (ToR)**	**Meeting Administration**	**SG Reporting**	**Policies & Procedures**	**Declarations of Interest (DOI)**	**Financial Accountability**	**Risk Management**
Morriston Service Group (MSG) 2025/26 - SLT, QSPE and RMG in place.	The SG Management Board is not meeting, and there is no robust decision-making forum with oversight of key health board priorities, including risk management, quality & safety, workforce, annual planning delivery and performance.	Some ToRs are not current, while others would benefit from enhancement to strengthen their content, including clarity over quoracy, approval dates, and escalation arrangements.	Work programmes are not consistently in place. Issues were identified with attendance and reporting by Radiology, and Divisional QSPE meetings relied predominantly on verbal updates.	Annual Plan Delivery review identified that MSG did not monitor or internally report progress against 2025/26 annual plan delivery actions.	No robust mechanism for oversight of reviews of policies and procedures.	No robust mechanism for overseeing DOIs, and no assurance reporting relating to consultants undertaking private practice.	Budget Setting review identified the absence of formal divisional budget delegation and that two 2025/26 budget accountability letters remain unsigned (by an ASGD and the interim SG Director (the latter had not been asked to sign a letter)).	Risk Management & Assurance review (2023/24) identified the need to improve consistency and completeness of operational risk registers, including management of long-standing risks, risk scoring and articulation of controls.
Neath Port Talbot & Singleton Service Group (NPTSSG) 2024/25 - SG Management Board, Business Assurance and Accountability	While escalation mechanisms exist, there is limited evidence to demonstrate that issues are escalated appropriately or that outcomes and discussions are formally recorded. No formal	Lack of evidence of formal approval for some ToRs, and others would benefit from enhancement to strengthen their content, including version control, quoracy, membership, reporting and	Work programmes are not consistently in place, and there is no mechanism to confirm quoracy for BAAM meetings.	Improvements identified in performance, workforce and financial reporting (e.g. clearer status criteria and workforce improvement plans). However, the Annual Plan Delivery review	No robust mechanism for oversight of policy and procedure reviews.	No robust mechanism for oversight of DOIs, including reporting on consultants undertaking private practice.	Divisional budget accountability letters were issued during 2024/25 but did not require signatures or specified the level of delegated budget.	Insufficient oversight and scrutiny of SG risks and inconsistent divisional risk reporting. Risk Management & Assurance review (2023/24) identified similar improvements required to operational risk

Service Group	Themes/ Key Findings Arising							
	SG Structure	Terms of Reference (ToR)	Meeting Administration	SG Reporting	Policies & Procedures	Declarations of Interest (DOI)	Financial Accountability	Risk Management
Meeting (BAAM), SLT and Quality, Safety and Risk Group in place.	mechanism exists for reporting from the SG Management Board to the health board's Management Board.	escalation arrangements.		identified that pausing of the BAAM process meant there was no monitoring or reporting of 2025/26 annual actions.				register quality and consistency.
Mental Health & Learning Disabilities Service Group (MHLD) 2023/24 - SG Management Board, SLT, and groups covering Workforce, Policy Reviews, Quality and Safety, Information Governance and Health & Safety in place.	Inconsistencies between actual and documented reporting lines. Report templates require enhancement to support clearer escalation, and no formal mechanism exists for reporting from the SG Management Board to the health board's Management Board.	ToRs not consistently in place; a number had passed review dates or lacked clarity over reporting arrangements.	Not all work programmes were in place. Some meetings were not quorate, and issues were noted with clinical attendance at quality and safety meetings.	Improvements identified in performance reporting, including clearer articulation of mitigating actions. Annual Plan Delivery review identified no issues.	N/A	No robust mechanism for oversight of DOIs or reporting relating to private practice.	The SG Director had not signed the 2023/24 budget accountability letter.	Insufficient oversight and scrutiny of SG risks. Risk Management & Assurance review (2023/24) again identified improvements to risk register quality and consistency.
Primary, Community & Therapies Service Group (PCT) – Not reviewed in full.	Reference noted to a SG Management Board and an Operational Business Meeting.	N/A	N/A	Annual Plan Delivery review identified no issues.	N/A	N/A	Budget Setting review identified that while budget expectations were clearly communicated at SG Board and other meetings, formal budget delegation was not signed at either ASGD or divisional level.	Risk Management & Assurance review (2023/24) identified the need to improve consistency and completeness of operational risk registers.

Appendix B: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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.

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

Public Sector Internal Audit Standards

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

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