Annual Plan Delivery

Final Internal Audit Report

2025/26

Swansea Bay University Health Board

Limited Assurance

Contents

Review Reference	SBU-2526-09
Fieldwork	January - March 2026
Executive Sign Off	11 May 2026
Audit Committee	21 May 2026
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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To assess the effectiveness of the arrangements in place to support the delivery of the 2025/26 Annual Plan.

Overview

The Integrated Medium-Term Plan (IMTP) is a three-year strategic plan that all health boards and NHS trusts are required to produce in line with Welsh Government requirements. Swansea Bay University Health Board (the health board) was unable to comply with its statutory duty to produce a financially balanced three-year IMTP, a contributory factor in the continued application of targeted intervention (escalation level 4) for finance, strategy and planning. An Annual Plan (the Plan) has been developed, setting out actions and outcomes planned for delivery in 2025/26, which has been mapped to Ministerial Delivery Expectations and Cabinet Secretary's Enabling Actions. This was considered by the Board on the 27 March 2025, when members concluded that the Plan could not be approved; however, it was submitted to Welsh Government for scrutiny and assessment purposes.

In September 2025, the health board published its updated Organisational Strategy, *A Healthier Swansea Bay*, which provides the strategic context and planning framework through to 2035. The Annual Plan sets out key priority areas for delivery during 2025/26, aligned to the five objectives outlined within the Strategy.

The Performance and Accountability Framework, approved by the Board on the 29 May 2025, has been refreshed to strengthen reporting processes and clarify internal escalation arrangements where performance falls outside of the agreed parameters. Further improvements are planned to strengthen the Framework to ensure there is sufficient performance, finance, and quality accountability that could enhance the annual plan delivery process further.

We have concluded **limited assurance** on this area. Since the 2025/26 Annual Plan's development, several new Executive Directors have taken up posts which may have resulted in shifts in strategic focus compared to those originally conceived. In addition, the pace and scale of organisational change across the health board, including improvements to Recovery and Sustainability and 'Organised for Success' programmes, have impacted delivery and reporting arrangements. This has resulted in weaknesses in oversight, despite the efforts of staff. Similar themes were identified in our internal audit review of Escalation Action Status (March 2026: Limited Assurance), which highlighted issues with oversight, accountability, and inconsistencies in escalation reporting. Although measures have been taken since quarter 3 (2025/26) and subsequent to the audit conclusion to strengthen reporting and oversight, these arrangements have not had sufficient time to embed to fully assess how they triangulate with specific delivery actions. The matters requiring management attention include:

- Clearer documentation of roles, responsibilities, and processes for the delivery of the Annual Plan including its publication on the health board's website.
- Improved clarity over progress against the 2025/26 delivery actions, recognising that the scale and volume of actions, alongside other performance measures, may impact deliverability. This reinforces the need for more integrated data collection and reporting to support prioritisation and focus effort on key areas of delivery.
- Finalisation and formal approval of the Integrated Planning and Performance Review's (IPPR) terms of reference, together with enhancements to meeting administration, including the recording of attendance and tracking of actions and issues raised.
- Addressing inconsistencies in reporting on Annual Plan delivery and in the categorisation of performance areas that are off track, and the need for a clearly defined escalation process to demonstrate that appropriate action is taken to address poor performance.
- Ensuring consistent and effective oversight of operational arrangements for monitoring delivery of the Annual Plan across service groups and programme boards.
- Reviewing the level and frequency of reporting to senior management, the Board, and committees to ensure sufficient oversight and scrutiny, while supporting improved integration of reporting processes.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. Highlighted for management information, there is also an opportunity to strengthen mechanisms for capturing feedback from annual planning exercises and for identifying and embedding improvements periodically throughout the year. Such represents an opportunity for enhancement and does not impact the overall audit opinion.

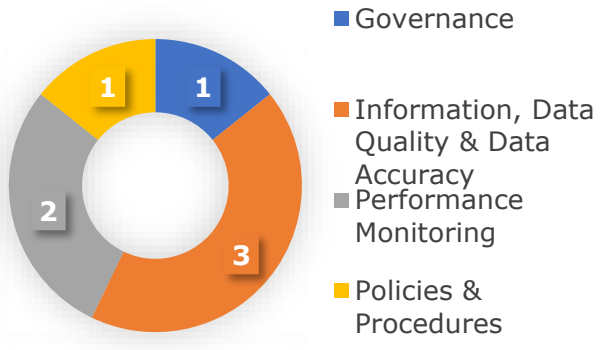
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Roles and responsibilities are clear to manage the delivery of the health board's Annual Plan.	1	**Reasonable**
2	There is a clear programme of delivery, with defined measures and milestones for Annual Plan priorities.	2	**Reasonable**
3	Performance monitoring of Annual Plan Delivery is effective, including mechanisms for escalation of issues and risks, and agreed action is taken where performance varies from planned delivery.	1, 3, 4, 5	**Limited**
4	Effective processes are in place within the service groups and programme boards for monitoring and reporting the delivery against their agreed annual plan.	1, 2, 6	**Limited**
5	Progress against the delivery of the Annual Plan is subject to regular oversight by the Board, its committees and Welsh Government.	2, 3, 7	**Limited**
6	There are opportunities for continuous improvement to assess how progress against the Annual Plan effectively informs the recurrent planning cycle.	-	**Reasonable**

Management Actions

1	6
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Roles and responsibilities are clear to manage the delivery of the health board's Annual Plan.	**Reasonable**

A corporate planning team provides support to the health board's main programme boards, for example, Unscheduled Care, Planned Care and Cancer, Mental Health and Learning Disabilities (MHLD) Care, and Women and Children's Care, and co-ordinates data collection related to Annual Plan delivery. In some Service Groups (SGs) and corporate areas, some staff members hold planning and performance responsibilities alongside their substantive duties. The 'Organised for Success' programme presents an opportunity to enhance organisational structures through the proposed establishment of a Delivery Unit, which is intended to support a more integrated performance function, with a remit that may include programme and project management, transformation, improvement, business intelligence, and performance management. SG structures are also under review as part of the programme, transitioning to six care groups to better align delivery to Welsh Government's (WG) priorities. Roles, functions and responsibilities within these revised arrangements are currently under development.

Documented guidance exists for both the annual planning and delivery processes, and is reviewed, circulated, and updated annually. Further refinement would assist to more clearly define roles and responsibilities and strengthen clarity over monitoring and reporting arrangements of the delivery process (see **Key Finding 1**).

The 2025/26 Annual Plan has not been published on either the health board's website or intranet due to it not being formally approved. We note, however, that other health boards in similar circumstances have made their annual plans publicly available. The Audit Wales Structured Assessment (October 2025) recommended opportunities to improve the accessibility of key documents, despite the health board taking steps to maintain up-to-date information on its website. We have not sought to replicate this recommendation at this report.

The health board has recognised the importance of strengthening accountability at an operational level within the planning and delivery process. Audit Wales also recommended in its Assessment that the health board should strengthen its performance management arrangements, through embedding the Performance and Accountability Framework (PAF), to support clearer accountability across performance, finance, and quality, including routine escalation reporting from each SG and corporate directorate to the Performance and Finance Committee (PFC). The PAF is currently being revised and, while it was due to be presented to PFC in February 2026 and to the Board in March 2026, it remained with Management Board for consideration at the conclusion of our fieldwork. We note that performance expectations are intended to be reinforced through the inclusion of accountability requirements within the 2026/27 accountability letters.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of Clarity in Documented Roles, Responsibilities and Delivery Processes** The '*Annual Plan 2025/26 Delivery and Execution Information Pack*' does not clearly define roles and responsibilities, nor does it fully specify the processes for recording, monitoring, reporting, and escalating issues, or for managing significant changes to Annual Plan delivery. Although the guidance outlines the intended reporting and governance structure, it notes that revised governance and reporting arrangements were under consideration by the Executive Team in June 2025, with further details to be confirmed and shared. At the time of this review, the guidance has not been updated to reflect current arrangements or to provide clarity on revised reporting and escalation requirements.	Unclear roles, responsibilities, and processes increase the risk of duplication of effort, gaps in accountability, or key tasks not being undertaken. This may, in turn, weaken oversight and decision making and limit the health board's ability to effectively manage delivery of the Annual Plan.	**Agreed Action:** This finding will be addressed through the revised Performance and Accountability Framework, supported by an Annual Plan execution pack. The Performance and Accountability Framework will clearly define the roles, responsibilities and accountabilities for Annual Plan delivery across Executive Directors, Service Groups / Care Groups, Programme Boards, IPPR, Management Board, PFC and Board. The Annual Plan execution pack will set out the operational process for recording, monitoring and reporting Annual Plan delivery, including escalation routes and thresholds, governance arrangements for oversight, and arrangements for managing and approving significant changes to Annual Plan priorities, milestones or actions. The updated arrangements will be communicated to all relevant delivery and oversight leads. Performance and accountability expectations will also be reflected in the 2026/27 accountability letters.
			Expected Evidence of Implementation: • Board-approved revised Performance and Accountability Framework. • Approved Annual Plan execution pack, including roles and responsibilities, reporting timetable, escalation routes, escalation thresholds and change-control arrangements. • Standard monitoring and escalation templates. • Evidence of communication to Service Groups / Care Groups, Programme Boards and Executive leads. • Signed 2026/27 accountability letters confirming Annual Plan delivery and escalation responsibilities.
		Medium Priority	**Officer:** Marie Davies, Executive Director of Planning and Partnerships
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 30 June 2026

Objective 2: There is a clear programme of delivery, with defined measures and milestones for Annual Plan priorities.	**Reasonable**

The Annual Plan is structured around five strategic objectives and is divided into defined 'system areas': Primary and Community Care; Unscheduled and Emergency Care (UEC); Planned Care; Cancer; MHLD; and Children and Young People, Women's Health (CYPWH) and Perinatal. Each system area is supported by a 'Plan on a Page', which outlines the key priorities for delivery in 2025/26 and provides a high-level overview of the associated delivery actions.

During 2025/26, the approach to monitoring the delivery of the Annual Plan evolved. Originally, the corporate planning team maintained a robust spreadsheet recording all delivery actions across each SG, including reference numbers; status (RAG-rated); mitigating actions; timescales; and escalations where appropriate. SGs were required to provide quarterly updates in line with agreed reporting timescales and to note any amendments to the delivery actions. Between Quarters 2 and 3, delivery actions were refreshed to remove those no longer relevant and to incorporate new actions, and system priority areas were also updated to reflect these changes. However, our review identified a vast number of delivery actions remaining to be delivered for 2025/26. When considering alongside staff capacity constraints and competing organisational priorities, such as the Recovery and Sustainability programme, this raises concerns around overall achievability (**Key Finding 2**).

From Quarter 3 onwards, the corporate planning team moved to a slide-based reporting approach, focusing on system-level priority areas rather than SG-level actions. These reports are updated quarterly by the identified leads to assist with streamlining reporting for senior management, the Board and PFC. The expectation was that SGs would still maintain their own mechanisms for tracking progress with their delivery actions, but as noted in **Key Finding 2** and *Objective 4*, this has been applied inconsistently, and overall progress is now unclear (**Key Finding 2**). In addition, some actions may no longer be current and may have been superseded by priorities included within the 2026/27 Annual Plan. The Plan on a Page approach provides a high-level overview of progress against priority areas rather than detailed actions but does highlight areas that are 'off track', reasons for variances, expected recovery timescales, and escalations where required.

The health board recognises the need to strengthen triangulation of data across key performance dashboards, including quality, safety, risk, and performance to assist in the delivery of the Annual Plan. This would be consistent with the WG's Escalation Framework, which outlines the consolidation of previous performance reviews and improvement plans into one core document, reducing the risk of duplication, and providing a clear way forward for adding value. Alternative tools to support the recording of Annual Plan delivery, including Microsoft Lists, have been explored, but user feedback was mixed so is no longer used. No further action is being proposed at this time.

The strategy and planning maturity self-assessment submitted to WG in November 2025 (see *Objective 5*), identified that, while a structured approach to monitoring Annual Plan and IMTP delivery was in place, with ownership of delivery emerging across services and key milestones and actions tracked, "*integration with performance and risk management is limited*." An action was therefore agreed to, "*introduce programme-level dashboards for IMTP delivery tracking*" by June 2026.

Similarly, an Executive Team meeting held on 11 March 2026 identified the need for a more "*structured approach to using national performance dashboards, including how these will support Board assurance and benchmarking.*" It was also noted that performance reviews needed to better, "*identify themes and triangulate issues across programmes,*" "*rather than treating actions in isolation*."

Key Findings		Risk & Impact	Agreed Management Action
2	**Inconsistent Monitoring and Reporting of Annual Plan Delivery Performance** During 2025/26, the corporate methodology for monitoring Annual Plan delivery changed at Quarter 3, transitioning from detailed tracking of delivery actions to a high-level 'Plan on a Page' approach. This revised approach required Service Groups (SG) to maintain their own mechanisms for tracking progress against delivery actions, although no documented evidence has been provided to demonstrate how this change was communicated or how SGs were expected to implement these revised arrangements. Our review identified inconsistent application of data collection and monitoring practices across SGs (see *Objective 4* and Key Finding 6). As a result, overall progress against individual delivery actions, and their continued relevance, cannot be clearly or consistently determined. The health board has been ambitious in the number of delivery actions identified for 2025/26, which have increased during the year. There was a total of 331 actions (147 of these were with Morriston SG and 65 with Neath Port Talbot and Singleton (NPTS) SG, noting some of these actions were programme level rather than SG-specific) when corporate monitoring ended (October 2025). When considered alongside other performance priorities and capacity pressures, the scale of actions raises concerns regarding overall achievability. This reinforces the need to review prioritisation and to strengthen data integration to enable clearer, more concise reporting.	Ineffective monitoring arrangements may result in duplication of effort, inefficient use of resources, limited oversight, and an increased risk that Annual Plan priorities are not delivered effectively.	**Agreed Action:** We will finalise a streamlined and prioritised 2026/27 Annual Plan, ensuring that the number of delivery actions is proportionate to organisational capacity and aligned to the Health Board's strategic priorities and breakthrough objectives, and including Welsh Government expectations and areas of escalation. Annual Plan delivery will be monitored through a standardised reporting mechanism embedded within the revised Performance and Accountability Framework. This will provide a consistent approach across Service Groups / Care Groups and Programme Boards and will support corporate-level reporting through the Integrated Performance Report and/or Plan on a Page reporting. The monitoring process will include clear ownership, milestones, outputs, outcomes, RAG status, mitigating actions, recovery dates and escalation routes. Reporting requirements will be standardised but proportionate to the priority and escalation status of each area, to avoid unnecessary duplication. Expectations for monitoring, reporting and escalation will be communicated to all Service Groups / Care Groups and Programme Boards through the Annual Plan execution pack. **Expected Evidence of Implementation:** • Final 2026/27 Annual Plan demonstrating rationalisation and prioritisation of delivery actions. • Board-approved revised Performance and Accountability Framework. • Approved Annual Plan execution pack setting out monitoring, reporting and escalation requirements. • Approved standardised Annual Plan monitoring template / reporting tool. • Evidence of communication to Service Groups / Care Groups and Programme Boards. • Sample corporate Annual Plan delivery report demonstrating consistent reporting against priority actions, milestones, outcomes, owners, RAG status, mitigating actions, recovery dates and escalation routes.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Marie Davies, Executive Director of Planning and Partnerships / Karen Stapleton, Deputy Director of Planning & Partnerships **Target Implementation Date:** 31 October 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Performance monitoring of Annual Plan Delivery is effective, including mechanisms for escalation of issues and risks, and agreed action is taken where performance varies from planned delivery.	**Limited**

A new method of oversight was implemented for 2025/26 replacing the Annual Plan Oversight Group. The Integrated Planning and Performance Review (IPPR) was established which convenes on a quarterly basis. The IPPR is chaired by the Chief Executive, and its membership benefits from full Executive Director involvement and representation from Digital and Workforce.

Although terms of reference have been drafted, they remain unapproved (see **Key Finding 3**). The PAF details that the IPPR's intended remit includes, "*ensure that performance delivery, which is predicated on cross system working rather than the accountabilities within each delegated area, is clearly set out and joint objectives/actions agreed as required. This meeting will also consider Divisional progress against its specific actions set out in the health board plan and will be subject to the requirement for an additional return (slide deck), reflecting this, on a quarterly basis. The IPPR will consider the key performance indicators (working towards a standard performance dashboard by Division) and will be supported by agreed action notes and a formal letter from the Chief Executive. The progress reported against the annual plan will be summarised into an update paper, which will service as the quarterly update against the plan; and which will be submitted to Board and Welsh Government*." Whilst we recognise the PAF is currently being revised, our review indicates that the IPPR is not yet operating as intended (see **Key Finding 3**).

As described under *Objective 2*, the approach to monitoring Annual Plan delivery changed during the year, moving away from monitoring delivery actions at a corporate level to a 'Plan on a Page' approach for most system areas (except for Digital and Workforce, who are not system areas and therefore continue to report on their progress with delivery actions). While this revised process remains under review, the transition has resulted in reduced reporting consistency, which has limited the effectiveness of oversight arrangements (see **Key Finding 4**).

While the template includes a prompt for escalation, such as 'decision required from IPPR', we note the formal escalation route is unclear (see **Key Findings 1** and **5**), and where escalation to the IPPR was required, outcomes and decisions were not consistently recorded (see **Key Finding 5**).

Minutes from the IPPR Quarter 1 meeting (July 2025) referenced some inconsistencies in the application of RAG ratings for Annual Plan delivery status. It is unclear what subsequent action was taken to address this (see **Key Finding 3**). Our review of Quarter 3 reporting, which has not yet been reported to the IPPR, PFC or Board at the time of fieldwork, also identified issues with the categorisation of 'off-track' performance areas (see **Key Finding 5**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Weaknesses in the Integrated Planning and Performance Review (IPPR) Governance, Operation and Oversight** The Integrated Planning and Performance Review (IPPR) was established in 2025/26 and met for the first time in July 2025. Draft terms of reference have been developed but remain unapproved. As a result, elements of IPPR's remit, as outlined in the Performance and Accountability Framework, have not been fully implemented. This includes the routine review of divisional progress against specific actions contained within the health board plan. The IPPR met twice during 2025/26: Quarter 1 (July 2025) and Quarter 2 (November 2025). The Quarter 3 meeting (January 2026) was stood down due to operational pressures, and a Quarter 4 meeting has been scheduled for the end of April. At the meetings that have been held, there have been gaps and inconsistent reporting that has impacted the IPPR's oversight of Annual Plan delivery. The Quarter 1 meeting was quorate and supported by detailed meeting notes. These highlighted a number of weaknesses, including the absence of quality and safety considerations, limited triangulation with finance, capital and estates information, missing performance metrics, and inconsistent application of RAG ratings. In particular, actions were noted as being on track against planned timescales while being 'off track' in terms of impact or expected performance. The Quarter 2 meeting was repurposed to primarily focus on the development of the 2026/27 Annual Plan. As a result, no detailed meeting minutes are available to confirm attendance, quoracy, or whether issues raised in Quarter 1 were revisited or addressed.	Unclear governance arrangements and inconsistent operation of the IPPR risk weakening accountability and oversight, reducing the effectiveness of performance challenge and escalation, and increasing the likelihood that key Annual Plan priorities are not delivered.	**Agreed Action:** The role of the Integrated Planning and Performance Review will be defined within the revised Performance and Accountability Framework, ensuring that its remit, membership, frequency, quoracy, reporting responsibilities and escalation responsibilities are clearly defined. The IPPR Terms of Reference will be finalised, approved and implemented. These will confirm IPPR's responsibility for scrutinising progress against Annual Plan delivery, reviewing areas of underperformance, agreeing actions where required, and escalating material risks or decisions through the appropriate governance route. The revised arrangements will ensure that IPPR operates as a key component of the Health Board's integrated performance and accountability arrangements, avoiding duplication with other reporting forums while providing clear oversight of Annual Plan delivery. **Expected Evidence of Implementation:** • Board-approved revised Performance and Accountability Framework. • Approved IPPR Terms of Reference aligned to the Performance and Accountability Framework. • IPPR minutes evidencing Executive Director attendance, quoracy, scrutiny, decisions, escalation and action tracking. • IPPR action log showing actions agreed, owners, timescales and progress updates. • Evidence of escalation from IPPR to Executive Board, PFC or Board where required.
		Medium Priority	**Officer:** Marie Davies, Executive Director of Planning and Partnerships **Target Implementation Date:** 31 July 2026
	Theme: Performance Monitoring	Control Operation	

Key Findings		Risk & Impact	Agreed Management Action
4	**Inconsistent Annual Plan Reporting** Although a 'Plan on a Page' reporting template exists for recording progress against Annual Plan priority areas, several inconsistencies were identified in its application across system areas and reporting periods: • Significant changes to the Annual Plan could not be clearly tracked, because reference numbers were not utilised for the respective priority areas. In addition, some priority areas and actions reduced between reporting periods (following a re-prioritising exercise), most notably within Planned Care, Digital and Workforce, without a clear audit trail. • Some areas, including Primary Care and CYPWH and Perinatal, omitted updates across all identified priority areas, but Planned Care reported against a greater number of areas than originally identified. • It is accepted that Digital and Workforce continue to report delivery actions, rather than provide summary dashboards like other system areas. However, this reduces comparability across reports. Furthermore, Quarter 1 and 3 reporting included progress against both milestones and measures, whereas Quarter 2 reporting was limited to milestones only due to the meeting date being prior to the availability of the required data.	Inconsistent and incomplete reporting reduces transparency and comparability, weakening accountability and oversight. This limits the availability of senior management and the Board to make well-informed decisions and effectively challenge and support delivery of Annual Plan priorities.	**Agreed Action:** SBUHB has adopted an outcomes and output-based performance approach to drive tangible improvements across the system. Standardised metrics are be used across each of our assurance and performance management fora. The reporting approach is designed to support consistency and comparability across Service Groups / Care Groups and Programme Boards, while remaining proportionate to the level of Board priority and escalation status. This enables the Health Board to maintain a clear audit trail of changes and provide consistent visibility of progress, risks, issues and required escalations. Annual Plan reporting is aligned with existing performance reporting wherever possible, including the Integrated Performance Report and Plan on a Page approach, to reduce duplication and support integrated oversight. **Expected Evidence of Implementation:** • Demonstration that organisation is focusing on its priority objectives and has robust escalation processes in place which it is following. This will be evidenced by the papers and minutes of the new governance arrangements set out in the PAF. • Evidence of communication to Service Groups / Care Groups and Programme Boards with agreed template.
		Medium Priority	**Officer:** Marie Davies, Executive Director of Planning and Partnerships **Target Implementation Date:** 31 July 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
5	**Weaknesses in Annual Plan Performance Categorisation and Escalation** The Annual Plan reporting framework applies a RAG status where delivery is assessed as 'off-track', defined as amber where, "*management and mitigating actions are in place*", and red where "*there is a significant issue which requires escalating*". **Milestones** For Quarter 3 reporting, there were a total of 132 milestones - 45 were categorised as amber, predominantly within UEC, MHLD and Digital. A further four milestones, relating to MHLD and Digital, were rated red and three of these prompted for an IPPR decision by MHLD. However, our review identified weaknesses in the quality and consistency of supporting information. Of the amber-related milestones, 18% (8) did not have mitigating actions recorded, and 36% (16) did not define an expected recovery date. This limits assurance that amber ratings were underpinned by effective management. In addition, some areas, particularly UEC, remained persistently 'off track' yet continued to be rated amber (there were 14 milestones rated amber in Quarter 3 compared to 9 in Quarter 2), without clear evidence of escalation to the IPPR. This raises questions as to whether escalation thresholds were being applied consistently, or whether the RAG rating criteria themselves require review. Planned Care did not apply a RAG rating to two out of 19 milestones, further reducing consistency. **Measures** Quarter 3 reporting indicated that a significant proportion of its 26 key outputs and measures were rated red: 33% for Planned Care and Cancer; 100% for Primary Care and Community, and also for CYPWH and Perinatal; and 50% for MHLD. However, the report did not consistently explain the underlying reasons for these ratings or set out the actions being taken to address performance. No equivalent analysis was provided for Digital or Workforce.	Weaknesses in the inconsistent categorisation, explanation and escalation of off-track performance increase the risk that key delivery issues are not identified or addressed in a timely manner. This may undermine effective decision-making, reduce accountability, and adversely impact the health board's ability to deliver its Annual Plan priorities.	**Agreed Action:** The revised Performance and Accountability Framework will also define escalation thresholds and triggers, including when matters should be escalated to IPPR, Management Board, PFC, Board or Welsh Government. Reporting requirements will be proportionate to the priority and escalation status of each area, while ensuring that persistent underperformance is clearly identified, reviewed and escalated where appropriate. Empower the assurance committees to review and establish the RAG performance criteria for milestones and measures, by which they will determine the requisite escalation and mitigations required. Put in place reporting requirements across the system which are proportionate to the prioritisation the board has attached to the strategic objective and the present level of escalation, on which the assurance committees will make their assessment. **Expected Evidence of Implementation:** • Board-approved revised Performance and Accountability Framework. • Approved RAG categorisation criteria for Annual Plan milestones, measures and outcomes. • IPPR, Management Board, PFC and/or Board minutes evidencing review, challenge and escalation of amber/red-rated areas.
	Theme: Information, Data Quality & Data Accuracy	**High Priority** Control Design	**Officer:** Marie Davies, Executive Director of Planning and Partnerships **Target Implementation Date:** 31 July 2026

Objective 4: Effective processes are in place within the service groups and programme boards for monitoring and reporting the delivery against their agreed annual plan.	**Limited**

As outlined in *Objective 2*, there was an expectation that a mechanism for recording and monitoring progress with delivery actions would be maintained operationally by SGs and programme boards, despite this no longer being required at a corporate level. We reviewed the four SGs (MHLD, Morriston, NPTS and Primary, Community and Therapies (PCT)) with the UEC programme board, the latter being selected for our sample as a review of UEC Governance arrangements was being carried out concurrently (report issued March 2026: limited assurance). There was variation in the tools and processes used to monitor and report progress against these actions (see **Key Finding 6**). This variability was compounded by differences in staffing capacity, most notably the absence of dedicated planning and performance support within Morriston.

Some SGs reported challenges in tracking performance following the shift to the 'Plan on a Page' approach. Noting that the templates required further refinement and that more integrated reporting was needed to avoid duplication (see **Key Finding 2**). Some SGs were also unaware that they were still expected to track detailed delivery actions. This reinforces the need for clearer accountability (see *Objective 1*), alongside clearly defined roles, responsibilities and processes for delivering the Annual Plan (see **Key Finding 1**).

The extant PAF, approved May 2025 (which we note is currently being revised: see *Objective 1*), sets out expectations that, "*the reporting for the quarterly reviews for Service groups will be based on the established "performance statement" product issued by the performance department each month and it will be expected that the Service Groups report this information, through a PowerPoint pack to aid discussion based on priority areas and exception. The PowerPoint pack will go beyond what is discussed by exception in the monthly review meetings and will seek to provide a full quarter overview aligned with priorities set out as part of the annual plan"*.

Similarly, the Management Board approved the governance structure for oversight of Annual Plan delivery in June 2025 (see *Objective 5*), which requires SGs to report progress through monthly performance reviews to the Chief Operating Officer and quarterly to Executive Directors, with programme boards reporting quarterly to the IPPR. The monthly SG reporting includes the submission of regular performance statements, providing oversight of progress with the key strategic objectives outlined in the Annual Plan. However, there is a further need to integrate reporting to prevent duplication, ensure there is adequate oversight of performance with delivery actions and that escalations are clearly evidenced (see **Key Finding 6**).

While the UEC Programme Board receives updates on priorities linked to both the Annual Plan and the wider UEC programme, the number of Annual Plan delivery actions directly overseen by the Programme Manager remained under review at the time of our audit.

	Key Findings	Risk & Impact	Agreed Management Action
6	**Lack of Consistent Service Group Monitoring of Annual Plan Delivery** MHLD and PCT SGs continue to utilise the corporate template to record and track progress against their Annual Plan delivery actions. NPTS SG appears to follow a similar approach, however, supporting information was not supplied prior to completion of the audit. In contrast, Morriston SG and UEC Programme Board have not maintained operational monitoring records since the transition to the 'Plan on a Page' reporting format, resulting in limited visibility of progress against their delivery actions since October 2025. MHLD and PCT undertake regular reporting of progress against their respective Annual Plan actions at SG level. NPTS previously operated a reporting process through its Business Assurance & Accountability meetings; however, this was paused in September 2025 to prioritise the Recovery and Sustainability programme. Management advised that previous reporting arrangements are expected to resume from April 2026. Morriston does not operate a formal reporting process for monitoring Annual Plan delivery. While there has been oversight of Annual Plan delivery progress, predominantly at the SG quarterly performance reviews, this duplicates the IPPR reporting concentrating on system areas. Therefore, there is no oversight of performance with the delivery actions.	Inconsistent operational monitoring and operational arrangements reduce visibility of progress and limit timely identification and escalation of delivery risks. This increases the poor performance is not addressed, undermining accountability and the effective delivery of Annual Plan priorities.	**Agreed Action:** Service Group / Care Group and Programme Board accountability for Annual Plan delivery will be defined through the revised Performance and Accountability Framework. The Framework will set out the requirement for Service Groups / Care Groups and Programme Boards to maintain appropriate oversight of their Annual Plan priorities, milestones and actions, including monitoring progress, identifying delivery risks, agreeing mitigating action and escalating material issues. Programme Board Terms of Reference will be reviewed and updated, where required, to ensure that responsibilities for overseeing and escalating Annual Plan delivery are clearly defined. The Annual Plan execution pack will provide supporting guidance on monitoring, reporting and escalation expectations. These arrangements will be aligned with the corporate reporting process to avoid duplication and ensure that operational monitoring supports IPPR, Management Board, PFC and Board oversight. **Expected Evidence of Implementation:** • Revised Performance and Accountability Framework. • Issued 2026/27 accountability letters. • Approved guidance on Annual Plan monitoring, reporting and escalation. • Updated Programme Board Terms of Reference. • Templates provided to SGs and Programme Boards to enable them to carry out consistent monitoring and reporting of Annual Plan actions.
		Medium Priority	**Officer:** Marie Davies, Executive Director of Planning and Partnerships **Target Implementation Date:** 31 July 2026
	Theme: Performance Monitoring	Control Design	

Objective 5: Progress against the delivery of the Annual Plan is subject to regular oversight by the Board, its committees and Welsh Government.	**Limited**

Audit Wales highlighted in its Structured Assessment (October 2025) that, "*the health board has generally good arrangements for monitoring delivery of corporate plans and strategies, but opportunities remain to strengthen these arrangements further*." Improvements have since been made to the level of detail within performance reports presented to the Board and PFC, including the introduction of a combined monthly escalation and Integrated Performance Report (IPR), replacing the previous quarterly reporting cycle, incorporating performance against the health board's Organisational Strategy, which has been aligned to the Annual Plan. Annual Plan reporting has been integrated into the IPR report rather than being presented as a standalone quarterly report, as was the case in 2024/25, following a request from PFC (24 June 2025) for more streamlined reporting to increase time for financial oversight.

Audit Wales also reported, through its 2022 Structured Assessment, "*the Integrated Performance Report has improved but opportunities exist to improve it further. The health board should look at opportunities to use digital solutions to present the report as well as include comparative data for other NHS bodies across Wales*." Despite the changes in reports presented, we note that this recommendation was recorded as 'in progress' at the time of their latest assessment.

Deloitte was commissioned by the health board in July 2025 with their remit including strengthening areas relating to the financial plan and the Recovery and Sustainability Board (RSB). The RSB's remit is centred on financial sustainability and discussions across the health board have understandably been focused on improvements within this area, which were not recorded as priorities within the original plan (the 2026/27 Annual Plan is expected to place greater emphasis on financial priorities).

Management Board (18 June 2025) approved the governance arrangements for oversight of Annual Plan delivery, which detailed that the IPPR should provide a quarterly Annual Plan update to Management Board, Board, and its committees through the IPR report; and the SG performance reviews would provide them with monthly IPR reports. While there was consistent monthly IPR reporting, only one Annual Plan update has been submitted to PFC and Board to date (see **Key Finding 7**). An update for Quarter 3 was expected in March 2026, but this did not occur due to prioritisation of the 2026/27 Annual Plan.

Furthermore, the governance structure outlined that Management Board would receive regular oversight of the Annual Plan delivery with the provision of IPR and escalation reports, along with financial updates. Despite monthly IPR and escalation reports being provided to Management Board, there is a lack of evidence to confirm that there is sufficient attendance by Executive Directors at IPPR meetings, (see **Key Finding 7**) and IPPR meetings are not operating as intended (see **Key Finding 3**). Despite measures being taken to enhance reporting, further work is required to streamline reporting to reduce duplication while ensuring adequate visibility of annual plan delivery (**Key Finding 2**), and we note that the intention is for Deloitte to review the monitoring and reporting arrangements in place with the Annual Plan. Currently, while the streamlining of reporting between the IPR, escalated areas, and Annual Plan delivery updates are recognised, the current integrated approach does not consistently provide sufficient visibility or assurance over progress against Annual Plan priorities. Discussions are understandably dominated by areas subject to targeted intervention. As a result, there has been limited routine discussion and challenge of wider Annual Plan delivery during the year (see **Key Finding 7**). Our review of other NHS Wales organisations, in the same escalation category for planning, noted that the majority report annual plan delivery separately to IPR reporting.

Given the health board's continued escalation status for planning, strategy and finance, regular meetings take place with WG, including monthly updates on escalated areas. An annual strategy and planning maturity self-assessment is also required to evaluate planning processes and ambitions against six domains, identify evidence of progress, and support a more integrated approach to planning. The latest submission to WG

(November 2025) identified actions including strengthening the IPPR meetings (by May 2026); promoting and widening use of planning templates which include triangulation evidence across operational planning aligned to Annual plan/IMTP process (by March 2026); and agreeing a governance and accountability framework (by March 2026). Positive feedback has been received from WG in relation to the submission.

Key Findings		Risk & Impact	Agreed Management Action
7	**Annual Plan Delivery Oversight by Board, PFC and senior management** The 2025/26 Annual Plan was not approved by either the Board or Welsh Government; and there has been limited oversight of reporting of Annual Plan delivery to PFC and the Board and no evidence of scrutiny when it has been reported. Progress for both Quarters 1 and 3 was not reported; and Quarter 2 was reported to both Board and PFC in November 2025. There is also a lack of oversight by senior management. The terms of reference state that all Executive Directors should attend the quarterly IPPR meetings. Review of the minutes for the first meeting (July 2025) meeting note that only 50% attended. Attendance was not recorded for the Quarter 2 meeting (November 2025), and no further meetings were held during 2025/26.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	**Agreed Action:** The reporting arrangements to senior management, executive board PFC & other committees and the UHB's Board will be strengthened as described in the responses in 1-6 above and will ensure: • Regular, timely reporting of Annual Plan delivery; • Clear visibility of progress along with risks and issues requiring escalation. **Expected Evidence of Implementation:** • Committee and Exec board meeting papers and minutes evidencing scrutiny, challenge and agreed actions. • IPPR meeting minutes evidencing Executive Director attendance and oversight.
		Medium Priority	**Officer:** Marie Davies, Executive Director of Planning and Partnerships
	Theme: Governance	Control Operation	**Target Implementation Date:** 31 July 2026

Objective 6: There are opportunities for continuous improvement to assess how progress against the Annual Plan effectively informs the recurrent planning cycle.	**Reasonable**

The Integrated Planning Group undertook a reflective exercise in April 2025 to identify good practice and lessons learned from the 2024/25 IMTP development process. Attendance at the session was limited, and although written feedback was subsequently requested, only one response was received. The feedback received highlighted strengths including a more focused plan, clearly communicated timescales, and strong support from the planning team. It was noted that the planning process evolved significantly during the course of the year due to changes in senior leadership and late availability of the WG Planning Guidance. Areas identified for enhancement included:

- the shift from the traditional Goal, Method, Outcome (GMO) approach to a delivery actions-based methodology, which created confusion for some teams.
- challenges were encountered with the use of Microsoft Lists to collate actions from SGs, alongside ongoing issues with Microsoft Excel such as version control and tracking updates. This prompted consideration of alternative digital tools to better support collaborative planning.
- unclear ownership of sections of the Plan, particularly within Morriston SG, exacerbated by the absence of dedicated planning leads. This contributed to a more siloed planning approach, with limited visibility of interdependencies across services.

We understand that a similar reflective exercise will be undertaken to review the 2025/26 Annual Plan process. This will need to consider how the level and breadth of feedback can be improved to better inform future planning cycles. Noting the number of significant changes experienced throughout the year, it would have been beneficial to capture learning through a continuous improvement mechanism; however, we recognise that this would have been challenging to achieve due to staff capacity constraints and the scale of ongoing organisational change within the health board.

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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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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