Public Audit & Assurance Committee

Tue 03 February 2026, 09:00 - 10:35

Microsoft Teams

Agenda

09:00 - 09:10
10 min

1. Preliminaries

David Edwards

1.1. Welcome, Introductions & Apologies for Absence:

David Edwards

1.2. Declarations of Interest

David Edwards

1.3. Minutes of the Committee meeting held: 18.11.2025

David Edwards

1.3 Public Audit Committee Minutes 18.11.25.pdf (7 pages)

1.4. Actions following meeting held: 18.11.2025

David Edwards

1.4 AA Action Log.pdf (1 pages)

1.5. Any Other Urgent Business

David Edwards

09:10 - 10:30
80 min

2. Internal Audit Progress Report including:

Ian Virgil

2.1 Internal Audit Progress Report February 26 cover.pdf (2 pages)
2.1a Internal Audit Progress Report February 26.pdf (30 pages)

2.1. Internal Audit Progress Report including (30 MINUTES):

Ian Virgil

All of the reports can be located in the supporting documents folder.

A. *GMS Unified Contract Assurance Framework (Substantial Assurance)*
B. *Additional Learning Needs Legislation (Reasonable Assurance)*
C. *Medical Equipment & Devices (Reasonable Assurance)*
D. *Standards of Business Conduct (Reasonable Assurance)*
E. *Children and Women Clinical Board Governance and Financial Arrangements (Reasonable Assurance)*
F. *Financial Sustainability (Reasonable Assurance)*
G. *Quality & Safety Governance (Advisory)*
H. *Follow-Up: Implementation of the Health Roster System (Assurance Not Applicable)*

2.2. Audit Wales Update including (20 MINUTES):

Wales Audit

A) Review of Eye Care Services - ***located in the supporting documents folder***

2.2 Audit Wales Update (February 2026).pdf (12 pages)

2.3. Audit Wales - 2025 Structured Assessment (10 MINUTES)

Wales Audit

2.3a Structured Assessment 2025 (Final).pdf (45 pages)
2.3b Management Response Form - CVUHB 2025 Structured Assessment (final).pdf (5 pages)

2.4. Audit Wales - 2025 Annual Audit Summary (10 MINUTES)

Wales Audit

2.4 CVUHB Annual Audit Summary 2025 (Final).pdf (16 pages)

2.5. Procurement Compliance Report (10 MINUTES)

Catherine Phillips

2.5 Procurement Audit Committee Board Report (1).pdf (7 pages)
2.5a STA's reported February 2026.pdf (1 pages)
2.5b Supplementary information for the Director of Finance - February 2026.pdf (3 pages)

10:30 - 10:35
5 min

3. Items for Approval/Ratification

3.1. Risk Management Policy

Matt Phillips

3.1 UHB 023 Risk Management Policy Jan 2026.pdf (24 pages)

10:35 - 10:35
0 min

4. Items for Noting & Information

4.1. Counter Fraud Progress Update

Henry Bales

4.1 COUNTER FRAUD PROGRESS COVER SHEET.pdf (2 pages)
4.1a COUNTER FRAUD PROGRESS REPORT.pdf (7 pages)

10:35 - 10:35
0 min

5. Agenda for Private Audit and Assurance Committee

David Edwards

i. *Approval of Minutes*
ii. *Counter Fraud Progress Update (Confidential – ongoing investigations)*
iii. *Audit of Accounts Reports Addendum*
iv. *People & Culture Assurance Report*

10:35 - 10:35
0 min

6. Any Other Business

10:35 - 10:35
0 min

7. Review & Final Closure

7.1. Items to defer to the Board / Committees & Review of Future Actions

David Edwards

7.2. Date and Time of the next Committee meeting:

David Edwards

Tuesday 19 May 2026 via MS Teams.

7.3. 10-minute break prior to Private Session

David Edwards

10:35 - 10:35
0 min

8. Declaration

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Minutes of the Public Audit & Assurance Committee Meeting
Held On 18 November 2025 at 9:00am
Via MS Teams

To view a recording of this meeting, please click here: Public Audit & Assurance Committee 18.11.2025 – Each item is linked below for ease.

Chair:		
David Edwards	DE	Committee Chair & Independent Member for ICT
Present:		
Ceri Phillips	CP	Vice Chair of the Health Board
Mike Jones	MJ	Independent Member – Trade Union
Rachna Upadhya	RU	Independent Member
In Attendance:		
Henry Bales	HB	Lead Local Counter Fraud Specialist
Rachel Freitag	RF	Audit Manager – Audit Wales
Lucy Jugessur	LJ	Deputy Head of Internal Audit
Robert Mahoney	RM	Deputy Director of Finance
Lianne Morse	LM	Deputy Director of People & Culture
Urvisha Perez	UP	Audit Lead - Audit Wales
Catherine Phillips	CPH	Executive Director of Finance
Matt Phillips	MP	Director of Corporate Governance
Claire Salisbury	CS	Deputy Director of Procurement
Frankie Thomas	FT	Head of Corporate Governance
Rhian Thomas	RT	Independent Member for Capital and Estates
Ian Virgil	IV	Head of Internal Audit
Kirsty Williams	KW	UHB Chair
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People and Culture

Item No	Agenda Item	Action
A&A 25/11/1.1	**Welcome, Introductions & Apologies for absence (click to view)** David Edwards (DE), the Independent Member for ICT and Committee Chair welcomed everyone to the meeting and apologies for absence were received.	
A&A 25/11/1.2	**Declarations of Interest (click to view)** **The Committee resolved that:** a) No Declarations of Interest were noted.	
A&A 25/11/1.3	**Minutes of the Committee meeting held 02.09.2025 (click to view)** The Minutes of the Meeting Held on the 02.09.2025 were received. **The Committee resolved that:** a) The draft minutes of the meetings held on 02.09.2025 were deemed to be a true and accurate record of the meeting	

A&A 25/11/1.4	**Actions following meeting held: 02.09.2025 (click to view)** The Actions were received. **The Committee resolved that:** a) The Actions were noted.	
A&A 25/11/2.1	**Internal Audit Progress Report: (click to view)** The Internal Audit Progress Report was received. Ian Virgil (IV), the Head of Internal Audit provide the Committee with an update on the status of the internal audit plan, noting that several audits had been delayed due to complex fieldwork, resourcing issues, and a request from the Health Board to delay one audit. He added that three audits had been finalised, four were in draft, and several were in progress, with confidence expressed that the plan would be delivered in time to inform the annual opinion. The Committee was advised that improvements had been highlighted in management response times to audit reports, with all responses received within the required timeframe, a positive change from the previous year. It was noted that some audits were proposed to be deferred or rescheduled, including the diabetes care process audit and others to 2026, pending Committee approval. Rhian Thomas (RT), the Independent Member – Capital, Estates & Facilities raised her concern about the clustering of audit reports toward the end of the year, suggesting a need for better scheduling and possibly adjusting the plan approval timeline in future years. IVI acknowledged the challenges and discussed possible adjustments for future planning. **DoLs (Deprivation of Liberty Safeguards) Audit (click to view)** Lucy Jugessur (LJ), the Deputy Head of Internal Audit summarised the DoLs audit which concluded with a reasonable assurance rating, identifying one high-priority and three medium-priority actions which included: • The absence of a DoLs policy in line with Welsh Government guidance (high) • No Standing Operating Procedure (SOP) in place (medium) • Insufficient staff training (medium) • Funding issues for assessments (medium) LJ reported that the Health Board had been paying for additional DoLS assessments beyond those covered by the local authority and was preparing a business case to request further funding to meet demand. Ceri Phillips (CP), Vice Chair of the University Health Board Ceri welcomed the audit and discussed the ongoing challenge of managing the interface between DoLS and Mental Health Act requirements, noting that the Mental Health Committee had been reviewing that to ensure appropriate assessments were conducted for all patients.	

	He noted that the audit findings reinforced the need to formalise processes and clarify responsibilities. Rachna Upadhya (RU), Independent Member emphasised the need for mandatory DoLs training and ensuring more than one trained staff member per ward. LJ noted that other Health Boards had mandatory training and that a training strategy was being developed. DE cautioned that making training mandatory did not guarantee compliance and suggested monitoring actual uptake. **It was noted that the audit would be taken to the next Mental Health Committee for noting and information.** **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report were considered. b) The proposed adjustments to the 2025/26 plan were approved.	
A&A 25/11/2.2	**Audit Wales Update (click to view)** The Audit Wales Update was received. Rachel Freitag (RF), the Audit Manager for Audit Wales reported that the audit of charitable funds accounts was underway with no significant findings so far, and the main accounts audit planning would begin early in 2026. Urvisha Perez (UP), the Audit Lead for Audit Wales provided an update on performance audit work, noting that the eye care service review and the 2025 structured assessment were at the reporting stage and would be presented at the February committee. She added that the digital transformation and clinical coding follow-up reviews were in progress, with other service reviews starting soon. DE asked for clarity on planning dates for reviews, and UP agreed to update the Committee with more precise scheduling in future reports. It was noted that the 2024/25 National Fraud Initiative (NFI) exercise was well underway, with participants actively reviewing data matches. UP informed the Committee about a briefing note providing national and local updates, and that local progress would be covered later in the agenda via the counter fraud update. She added that the NFI assessment involved governance and follow-up arrangements, with Cardiff and Vale having met with Audit Wales as part of the process and that insights from this assessment would inform the next national report, due in autumn 2026. **The Committee resolved that:** a) The Audit Wales Audit Updates were noted.	

A&A 25/11/2.3	**Deep Dive on Procurement and Non-Pay Spend (click to view)** The Deep Dive on Procurement and Non-Pay Spend was received. Claire Salisbury (CS), Deputy Director of Procurement presented a six-year trend analysis showing a significant increase in non-pay expenditure and purchase order usage, which improved data visibility and control over spending. She advised the Committee that the procurement team had moved continuing healthcare payments onto the Purchase Order (PO) system, allowing better tracking of patient placements and provider spend, and enabling more effective financial controls. Ongoing initiatives highlighted by CS included training on new procurement regulations, exploring AI for analytics, collaborating across regions, standardising clinical products, improving supply chain resilience, and supporting decarbonisation goals. CS also highlighted efforts to address areas with limited procurement influence, such as spot purchases in continuing healthcare and laboratory tests, with an aim to introduce framework contracts and competition where possible. RT asked if there was a system for delegated authority on low-value, low-risk spend, and how was non-compliance handled when procurement was not involved? CS responded that spend thresholds were managed via standing financial instructions (SFIs) and standing orders, with delegated authority up to £5,000 for budget holders, increasing requirements for quotes/tenders at higher values. She added that non-compliance was caught early, and NHS terms and conditions were applied via POs for protection. About 90% of products/services were on standard NHS terms. RU asked CS about Artificial Intelligence (AI) readiness and data standardisation. CS responded that NHS Wales used a unified Oracle system and reporting tools, which supported standardisation and benchmarking for AI integration. Kirsty Williams (KW), The Chair for the University Health Board asked about timelines for improvements in continuing healthcare procurement and changes resulting from the deep dive. CS responded and estimated a 12-month timeline for implementing a framework for specialist placements and identified opportunities for standardisation and digital efficiency. DE raised his concerns about risks of single supplier dependency versus too many suppliers and asked what could be done to provide assurance. CS explained that dual supply was used for resilience in critical areas, and each category was managed to balance risk and efficiency. CP asked about carbon footprint considerations noting a large volume of contracts were from outside of Wales. CS described targeted interventions to maximise decarbonization, especially where local suppliers were available.	

	She agreed to further analyse and report on areas with single versus multiple suppliers to ensure the right balance between resilience and efficiency. • The committee noted the report and agreed to revisit procurement compliance and Chair's actions in the next agenda items. **The Committee resolved that:** a) The contents of the report were noted.	
A&A 25/11/2.4	**Procurement Compliance Report (click to view)** The Procurement Compliance Report was received. Claire Salisbury presented and reported to the Committee a 50% reduction in non-compliance cases compared to the previous period, attributing that to increased education and training efforts by the procurement team. She added that all breaches were discussed directly with operational management and had been actioned. The Committee was advised that contract value breaches dropped significantly (from 23 to 4), mainly in capital estates and planning, and were managed through contract change notices. It was noted that emergency activity non-compliances were reviewed regularly and made compliant by updating the contracts and that exemptions (e.g. rent payments) were now reported separately for transparency. CS concluded the report by noting that the number of single tender actions (STAs) and single quotation actions (SQAs) had dramatically reduced, with only one STA reported in the period and advised the Committee that the report now included more detailed narrative on reasons and actions taken, as requested by the Committee. **The Committee resolved that:** a) The contents of the report were noted and approved/agreed.	
A&A 25/11/2.5	**Procurement Compliance Report – Chairs Action Review (click to view)** The Procurement Compliance Report – Chairs Action Review was received where it was noted: • The number of chairs action requests had significantly decreased, from 45 in 2022/23 to just 3 in the current year. That reduction was due to increased delegated authority (threshold raised from £0.5m to £1m) and a more targeted approach to approvals. • Of the 3 recent Chairs actions, two were urgent Welsh Government funding requests for insourcing/outsourcing, and one was a managed service contract extension needed urgently due to a cost pressure. • The process had improved with support from Corporate Governance colleagues, and further reductions were expected, though some chairs actions would always be necessary for urgent or late funding situations. **The Committee resolved that:** a) The contents of the report were noted.	

A&A 25/11/2.6	**Triannual Audit Tracker update (click to view)** The Triannual Audit Tracker update was received. The Triannual Audit Tracker update focused on how the organisation was improving its approach to tracking and completing audit actions from internal audit, Audit Wales, and regulatory bodies. Matt Phillips (MP), The Director of Corporate Governance advised the Committee that the team had moved from fragmented spreadsheets to a centralised Audit Management and Tracking (AMAT) system, which automated tracking and provided better visibility. He noted that whilst the number of older actions was decreasing, a high percentage of overdue actions remained, prompting a review of how due dates were set to ensure they were realistic and achievable. The update highlighted ongoing efforts to migrate all regulatory action tracking into AMAT, improve reporting, and strengthen oversight—especially for high-priority actions. It was agreed that the committee would now review the tracker at every other meeting to maintain focus and drive further progress. KW asked how the methodology for setting due dates on audit actions was determined, noting that someone must have believed the dates were achievable when set, and questioned how the organisation ensured those dates were realistic and not simply accepted as a norm if overdue. MP responded that due dates were set through discussions between his team, auditors, and those responsible for the actions. He acknowledged that while the process was improving, there was still work to do to ensure dates were realistic and reflected the true effort required. He added that the relationship with auditors was becoming closer, which helped reinforce the importance of timely completion, and that the organisation was moving from a process-driven approach to one focused on quality improvement. IV and UP added that managers were the one to propose dates which were then reviewed and signed off by Executive leads, and that there was oversight to ensure dates were both challenging and achievable. **The Committee resolved that:** a) Assurance on the progress made for Internal Audit & Audit Wales audit actions to date was noted b) the progress undertaken to review the regulatory audit tracking process and support the actions identified to streamline the process for regulatory audit inspection tracking was noted.	
A&A 25/11/4.1	**Counter Fraud Progress Update** The Counter Fraud Progress Update was received. **The Committee resolved that:** a) The Counter Fraud Progress Update was noted.	

A&A 25/11/5	**Agenda for Private Audit and Assurance Committee** *i. Counter Fraud Progress Update (Confidential – ongoing investigations)* *ii. People and Culture Assurance Report*	
A&A 25/11/6	**Any Other Business** No Other Business was discussed.	
A&A 25/11/7.1	**Items to be deferred to Board / Committee** CP reiterated that the DoLS internal audit report would be received by the Mental Health Legislation Committee for noting.	
A&A 25/11/7.2	**Date and time of next committee meeting** 3 February 2025 via MS Teams.	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update	Comments
AUDIT & ASSURANCE	Internal Audit Progress Report: DoLs (Deprivation of Liberty Safeguards) Audit	A&A 25/11/2.1	Bring DoLS audit to the next Mental Health Legislation Committee for noting and information.	Jason Roberts (Cardiff and Vale UHB - Corporate Nursing);#610	Rachel Chilcott (Cardiff and Vale UHB - Corporate Governance)	18/11/2025	03/02/2026	**COMPLETE**	Received by the MH Committee on 27.01.2026	Received by the MH Committee on 27.01.2026
AUDIT & ASSURANCE	Deep Dive on Procurement and Non-Pay Spend	A&A 25/11/2.3	Include further analysis around areas with single versus multiple suppliers to ensure the right balance between resilience and efficiency on future Procurement Reports	Catherine Phillips (Cardiff and Vale UHB - Executive);#600	Claire Salisbury (NWSSP - Procurement)	18/11/2025	03/02/2026	**COMPLETE**	Work underway to ensure the right balance between resilience and efficiency is included on future reports - Supplier information provided under action/status column on report and will continue to add to all future procurement reporting.	Work to be undertaken to ensure the right balance between resilience and efficiency was included on future reports.

Report Title:	Internal Audit Progress Report			Agenda Item no.	2.1	
Meeting:	Audit & Assurance	Public	X	Meeting Date:	03/02/26	
		Private				
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Head of Internal Audit					

Main Report

Background and current situation:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Cardiff and Vale University Health Board.

The work undertaken by the Audit & Assurance Service is in accordance with its annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is subject to Audit & Assurance Committee approval. The plan sets out the program of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the engagement process established with the Health Board.

The 2025/26 plan was formally approved by the Audit Committee at its May 25 meeting.

The progress report provides the Audit & Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including commentary as to progress with the delivery of assignments.

Executive Director Opinion and Key Issues to bring to the attention of the Committee:

The progress report highlights the conclusions and assurance ratings for audits finalised in the current period.

The following reports have been finalised since the November 25 meeting:

- GMS Unified Contract Assurance Framework (Substantial Assurance)
- Additional Learning Needs Legislation (Reasonable Assurance)
- Medical Equipment & Devices (Reasonable Assurance)
- Standards of Business Conduct (Reasonable Assurance)
- Children and Women Clinical Board Governance and Financial Arrangements (Reasonable Assurance)
- Financial Sustainability – Temporary Staffing Controls (Reasonable Assurance)
- Quality & Safety Governance (Advisory)
- Follow-Up: Implementation of the Health Roster System (Assurance Not Applicable)

The Executive summaries of the final reports are included within the progress report, with the full version of the reports within the committee supporting papers.

The progress report also includes details of a proposed adjustment to the 2025/26 plan.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report.
- **Approve** the proposed adjustment to the 2025/26 plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	No	Not Required

Impact Assessment:

Risk: Yes/~~No~~ (delete as appropriate)

The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.

Safety: Yes/~~No~~

The progress report includes the outcome from an audit that provides assurance around controls and processes relating to patient safety.

Financial: Yes/~~No~~

The progress report includes the outcome from an audit that provide assurance around controls and processes relating to Finance.

Workforce: ~~Yes~~/No

The progress report includes the outcome from an audit that provide assurance around controls and processes relating to Workforce.

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

The progress report includes the outcome from an audit that provide assurance around reputational issues.

Socio Economic: ~~Yes~~/No - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***

Equality and Health: ~~Yes~~/No

Decarbonisation: ~~Yes~~/No

Welsh Language: ~~Yes~~/No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*

Committee/Group/Exec	Date:

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee February 2026

NWSSP Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2025/26 Internal Audit plan.

The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the plan and any required updates.

The plan for 2025/26 was agreed by the Audit & Assurance Committee in May 2025 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

The assignments noted in the table below had been planned to be reported to the February Audit Committee but did not meet that deadline.

Audit	Current Position	Draft Rating	Reason
Digital Literacy	Draft Report	Advisory	Delay in agreeing scope of audit and then management request to postpone commencement of fieldwork.
Wellbeing Hub Park View	Draft Report	Limited	Delay in agreeing report and receiving management actions.
Medical Staff Deployment	Fieldwork		Delay in completion of fieldwork due to availability of IA resources.
Clinical Board Adherence to the Managing Attendance at Work Policy	Fieldwork		Delays in meeting key contacts and receiving information required to undertake fieldwork.

3. Outcomes from Completed Audit Reviews

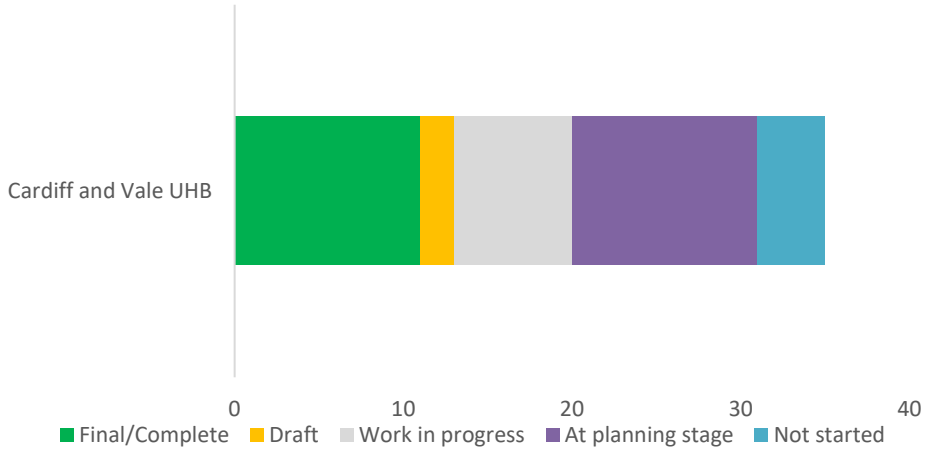
Eight assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The Executive Summaries from the final reports are provided in Section eight. The full reports are included separately within the Committee supporting papers.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
GMS Unified Contract Assurance Framework	Substantial	
Additional Learning Needs Legislation	Reasonable	
Medical Equipment & Devices		
Standards of Business Conduct		
Children and Women Clinical Board Governance and Financial Arrangements		
Financial Sustainability – Temporary Staffing Controls		
Quality & Safety Governance	Advisory	
Follow-Up: Implementation of the Health Roster System	N/A	

4. Delivery of the 2025/26 Internal Audit Plan

There is a total of 35 reviews within the 2025/26 Internal Audit Plan, (including the change highlighted below), and overall progress is summarised below.



The illustration above shows that eleven audits from the 2025/26 plan have been finalised so far this year and two others have reached the draft report stage.

In addition, there are seven audits that are currently work in progress with a further fifteen at the planning stage.

Full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A.

Appendix A also includes details of the audit from the 2024/25 plan that was not

sufficiently progressed to be included within the Head of Internal Audit Opinion for 2024/25. The audit has now been finalised, and the outcome will feed into the 2025/26 Opinion.

Appendix B highlights the times for responding to Internal Audit reports.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators (KPI).

5. Changes to the 25/26 Internal Audit Plan

An additional audit has been added to the plan covering Flexible Working Arrangements for Compressed and Variable Hours. The audit was requested following concerns raised by management over the current processes operating within the Medicine Clinical Board. The addition has been agreed with the Chief Operating Officer and Executive Director of People & Culture.

6. Development of the 2026/27 Internal Audit Plan

Meetings are being held with the Health Board's Executive Directors, Chief Executive, Chairman and Audit Committee Chair during February and March to discuss potential areas for inclusion within the 2026/27 Internal Audit Plan.

An initial draft plan will be submitted to a meeting of the Strategic Leadership Team during March for review. An updated draft will then be presented to the May Audit & Assurance Committee for formal approval.

7. Audit & Assurance Review Database

The Audit & Assurance Business Manager undertook a project in 2022 to review and collate data from the previous 4 years of completed internal audits for all 13 organisations within NHS Wales. This led to the creation of an Audit & Assurance Review database, and the outcomes of all audits have since been added to the database as they are completed. The collected data is all publicly available, within published reviews from NWSSP Audit and Assurance teams or within the Head of Internal Audit Annual Opinions.

A Power Bi report analyses the information within the database in order to highlight trends and themes to support with planning internally for the Audit and Assurance teams within NWSSP. It also provides the opportunity for Heads of Internal Audit and client organisations to investigate where findings or themes are consistently arising within each organisation or NHS Wales in totality.

The Business Manager has recently developed an additional Power BI report for sharing access to the database with NHS Wales organisations. For the Health Board, access has initially been provided to the Director of Finance, Director of Corporate Governance and members of the Corporate Governance team.

8. Final Report Summaries

8.1 GMS Unified Contract Assurance Framework

Substantial Assurance

Purpose

To review the processes for managing the GMS Unified contract performance framework and monitoring and reporting performance.

Overview

The new Unified Contract for general medical services (GMS) was negotiated over 18 months as part of a tripartite approach with Welsh Government, NHS Wales and the General Practitioners Committee (Wales) (GPCW).

The NHS (General Medical Services Contracts) (Wales) Regulations 2023 (2023 Regulations) underpinning the Unified Contract came into effect on 1 October 2023.

The Unified Contract for GMS will simplify what services all GP practices in Wales must provide and how they evidence assurance of delivery.

The key aims of the Unified Contract are:

- to make it easier for patients and healthcare professionals to understand responsibilities for the provision of services;
- to reduce administrative bureaucracy, freeing up time and resource for service delivery; and
- to enable use of data and technology to help plan resources and delivery of services.

The GMS Unified Contract Assurance Framework is in use across NHS Wales and by GMS contractors to provide assurance of delivery of the GMS Unified Contract. The Framework has been developed taking account of the context of the new Health and Care Quality Standards for Wales (2023).

The Framework is a governance process for the evaluation of assurance on services delivered through the Unified Contract, in the context of the Duty of Quality legislation, and has three components:

- A nationally agreed data set for quality, safety, governance and contract management. This comprises of a national set of indicators, a practice assurance return, Clinical Governance Self-Assessment Toolkit (CGPSAT) and IG toolkit.
- A nationally agreed process for assessing contractors' compliance against contractual requirements; and
- A nationally agreed escalation ladder for managing concerns, including an appeals procedure.

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

- Contract and Governance Visit Reports have not been issued to GMS Practices upon full completion of CAF assessments, which is not in line with the Welsh Government Contract Assurance Framework.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

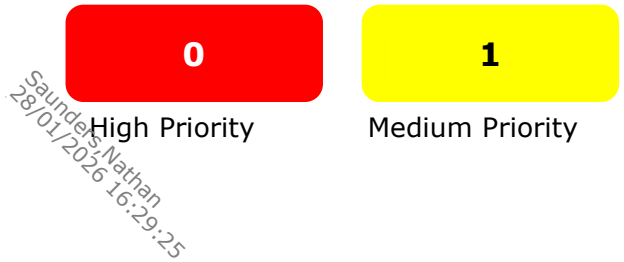
- Implementation of a Standard Operating Procedure in respect of the application of the Framework Escalation Ladder.
- Standard Practice Visit Assessment Agendas in respect of the 2023/24 CAF Assessment Cycle were not always issued prior to the visit.

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

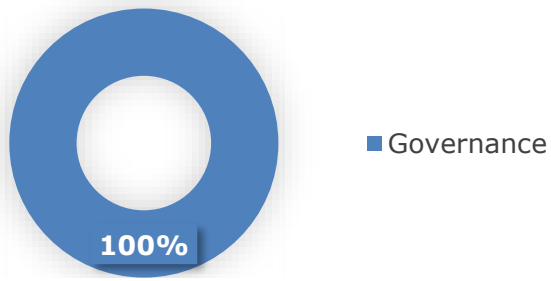
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Up to date procedure documents are in place setting out the Health Board's processes in relation to the Framework	-	**Substantial**
2	An assessment of practice assurance is undertaken for each of the GMS contractors against the National Indicators stated within the Unified GMS Contract and these are formally recorded, reported and outcomes reviewed by the Health Board	-	**Substantial**
3	Visits are carried out to those practices prioritised for further assessment, with timely verbal and written feedback provided, action plans agreed and monitored, and follow-up reviews planned	1	**Reasonable**
4	The stages of the Framework's Escalation Ladder are appropriately utilised for those practices where a breach or remedial notice may ultimately be issued by the Health Board	-	**Substantial**

Management Actions



Themes



Risk Types

Legal & Regulatory Non-Compliance

8.2 Additional Learning Needs Legislation

Reasonable Assurance

Purpose

Our review of the implementation of the Additional Learning Needs system was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board ('the Health Board'). The purpose of the audit is to provide assurance on the arrangements in place to ensure compliance with and adherence to the Additional Learning Needs and Education Tribunal (Wales) Act, Regulations made under the Act and the statutory ALN Code (the ALN system or legal framework).

The additional learning needs (ALN) system supports children and young people aged 0 to 25 in Wales with ALN and replaced from September 2025 two separate frameworks; i.e. the Special Educational Needs (SEN) system in schools and the Learning Difficulties and/or Disabilities (LDD) in further education.

The Act became lawful from September2021, but implementation was phased over a four-year period. In accordance with Section 61 of the Act, Local Health Boards must have a Designated Education Clinical Lead Officer (DECLO) for co-ordinating the Board's functions in relation to children and young people with ALN. Chapter 9 of the ALN Code details their specific roles and responsibilities. The Act also introduces three other statutory duties which are Section 65, Section 20 and Section 64. The Act also continues the existence of the Special Educational Needs Tribunal for Wales, which hears and decides appeals and applications in relation to children and young people who may have or have ALN but renames it the Education Tribunal for Wales.

Overview

We have concluded **Reasonable** assurance on this area. The significant matters requiring management attention include:

- The Health Board currently lacks an overarching ALN Governance Policy that clearly defines the overall governance arrangements and establishes organisational accountability for compliance with and adherence to the ALNET Act, Regulations and the ALN Code.
- Identification of ALN training needs and maintenance of attendance records for ALN training sessions have not occurred, resulting in an inability to assess training session participation levels.
- There is uncertainty about ALN Champions' training, development, and role expectations. Survey responses also revealed ongoing concerns and recurring questions about their responsibilities.
- The Health Board attendance levels at the Regional Health and Education ALNET Steering Group (RASG) is low, resulting in one meeting not being quorate.
- The Health Board lacks an overarching strategic ALN implementation document, nor has it developed a joint work plan between health and education partners.

- The Health Board has not been able to determine future ALN demand since the implementation of the system is still evolving and both legal and operational factors keep changing.
- The use and interpretation of weekly nudge reports vary, and there is no clear evidence to support that outstanding requests are being thoroughly scrutinised and challenged appropriately consistently by all services.
- There is inconsistent engagement with the Statutory Duty Monitoring (SDM) process across the various services.
- The ALN KPI dashboard trial in 2024 was paused due to uncertainty about Health ALN KPIs across Wales. The PARIS module is still in development, with the DECLO Team tracking changes since February, but limited access to PARIS development time slows progress.
- Attendance at the ALN Implementation Operational Group (ALNIG) meetings has been low; ten services, accounting for 45%, were absent from all of the sessions reviewed.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- ALN data shared at the Therapies Quality, Safety & Experience meeting shows that Occupational Therapies statutory compliance rates remain consistently low unlike other areas.
- The membership of the ALN Implementation Operational Group (ALNIG) is intended to be reviewed annually: however, as the terms of reference was last reviewed in July 2024, a review is now overdue.

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	Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans.	1	**Reasonable**
2	There is sufficient training and engagement with staff.	2,3	**Reasonable**
3	Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users.	4,5	**Reasonable**
4	There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes.	6	**Reasonable**
5	There are robust quality assurance measures in place to demonstrate compliance with the ALN Act.	7, 8, 9	**Limited**
6	There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal.	-	**Substantial**

7	Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met	10	**Reasonable**

Management Actions

2	8
High Priority	Medium Priority

Themes

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

8.3 Medical Equipment & Devices

Reasonable Assurance

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of Medical Equipment and Devices including implants.

The term 'medical equipment or device' includes all products, excluding medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. The range of products is wide and includes dressings, tubing, syringes, infusion pumps, heart valves, surgical instruments, resuscitators, radiotherapy machines, wheelchairs, walking frames or other assistive technology products.

A systematic approach to the acquisition, deployment, maintenance, repair and disposal of medical devices aligned with appropriate staff training and quality assurance arrangements will ensure that the use of medical devices is done safely, competently and effectively for the best care of patients and complies with all relevant legislation and guidance.

Testing of medical equipment and devices has been undertaken within Radiology at University Hospital of Wales (UHW) and University Hospital Llandough (UHL), Hospital Sterilisation and Decontamination Unit (HSDU) at UHW and Sterile Services Unit (SSU) in UHL.

This area was last reviewed during 2022/23 and was assessed as Reasonable Assurance.

Overview

We have concluded **Reasonable** assurance on this area. The significant matters requiring management attention include:

- Review of the policy and procedure is significantly overdue.
- Radiology medical equipment and devices are not accurately recorded on Medusa.
- A significant number of medical equipment and devices have overdue planned maintenance.
- Lack of Clinical Engineering oversight of Radiology and HSDU / SSU.

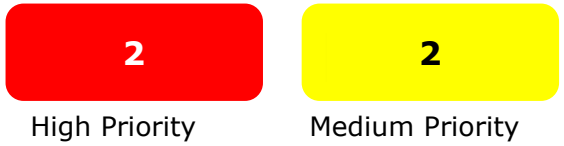
Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following issue represents an opportunity for enhancement that does not impact the overall opinion and is highlighted for management information:

- Commissioning paperwork could not be provided for one Radiology asset tested.

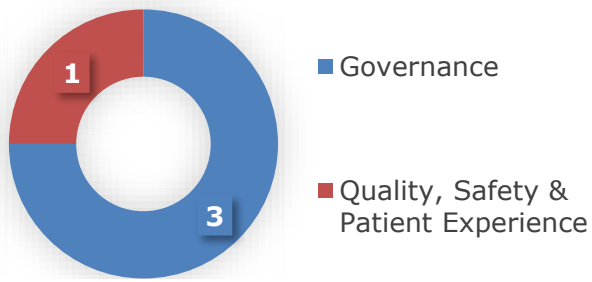
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Health Board has appropriate policies and procedures in place for the management of Medical Equipment & Devices, which are reviewed and maintained by the Medical Equipment Group. Staff are made aware of their responsibilities or any revisions to responsibilities following a review	1	**Reasonable**
2	There is a medical equipment inventory database that accurately records the purchase, transfer, loan and disposal of medical equipment and devices, with all equipment being disposed of appropriately	2, 3	**Limited**
3	Medical equipment and devices are cleaned and maintained and kept in an appropriate state of repair	4	**Reasonable**
4	Medical equipment and devices are suitably decontaminated after each patient use	-	**Substantial**
5	Medical equipment and devices are stored in a safe and secure location when not in use	-	**Substantial**
6	Risk assessments are completed on devices and equipment which may pose a significant risk to patients or staff and any incidents are recorded on Datix	-	**Substantial**
7	Staff receive appropriate training before using medical equipment and devices	-	**Substantial**

Management Actions



Themes



Risk Types

Quality or Safety Issues

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8.4 Standards of Business Conduct

Reasonable Assurance

Purpose

Our review of the Standards of Business Conduct was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board ('the Health Board'). The purpose of the audit was to review the adequacy of the systems and controls in place within the Health Board for the management of standards of behaviour. Including declarations of interests and declarations of gifts, hospitality and sponsorship.

The Welsh Government's 'Citizen-Centred Governance Principles' apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

All Health Boards should have a Standards of Behaviour Framework in place that sets out the arrangements for ensuring that all staff comply with the principles, including recording and declaring potential conflicts of interest and handling of gifts, hospitality and sponsorship.

Overview

We have concluded **Reasonable assurance** on this area. Our audit confirmed that appropriate procedures and processes are in place for the Standards of Business Conduct, however, declaration rates within the Health Board are low. The matters requiring management attention include:

- There was inadequate staff communication on ensuring that staff were informed that they had to declare Gifts, Hospitality, and Interests.
- There were low declaration rates within the Health Board.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The below opportunity for enhancement has been identified that do not impact the overall opinion and are highlighted for management information:

- Three Independent Members had yet to declare any interests, two had only been in post since October 2025 but one had been in post since June 2025.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has an appropriate and up to date Standards of Behaviour Framework Policy in place and this is widely available to all relevant parties		**Substantial**
2	Effective processes are in place to ensure that all employees and Independent Members are aware of the requirements of the Standards of Behaviour Framework and have access to appropriate information, support and advice	1	**Reasonable**
3	Effective arrangements are in place to ensure that specific groups of Employees and Independent Members complete a Declaration of Interest on initial employment with the UHB and that declarations are updated following any changes in circumstances	2	**Reasonable**
4	The Health Board has an up-to-date Register of Interests in place, and the content is reported to the Audit and Assurance Committee at agreed intervals		**Substantial**
5	Effective processes are in place for ensuring that employees and Independent Members declare any offer of a gift, hospitality or sponsorship which requires recording	1	**Reasonable**
6	A Register of all declared Gifts, Hospitality and Sponsorship whether, accepted or declined, is maintained and the content is reported to the Audit and Assurance Committee at agreed intervals		**Substantial**

Management Actions

0 High Priority

2 Medium Priority

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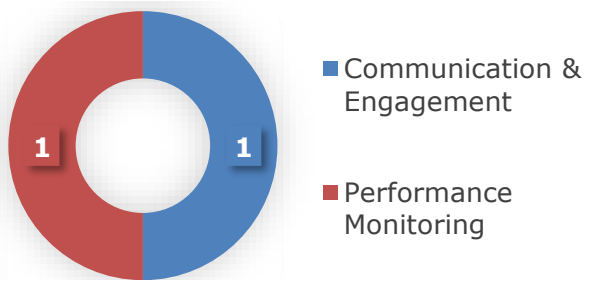
Themes



Risk Types

Public Perception & Reputational Risk

8.5 Children and Women Clinical Board Governance and Financial Arrangements

Reasonable Assurance

Purpose

Our audit of Children and Women (C&W) Clinical Board Governance and Financial Management Arrangements was undertaken and completed in line with the 2025/26 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

Overview

Governance structures and their applications are fundamental to ensuring the success of the Health Board in delivering its statutory obligations.

Good corporate governance plays a vital role in underpinning the integrity and efficiency of the Health Board and the wider community in which it operates. Robust properly developed and embedded governance structures are fundamental to ensuring the achievement of the Health Board's strategic objectives and in delivering its statutory, regulatory and legal requirements.

Each Clinical Board is led by a director and is required to have effective governance arrangements in place for the services they are accountable for, in order to provide assurance to the Board and its Committees on the quality and effectiveness of the services provided to its users, coupled with ensuring the aims and objectives set by the Board are delivered. Clinical Boards have delegated responsibility to manage their financial budgets, with support from designated Finance Business Partners.

Children and Women Clinical Board is responsible for a wide range of health services for children, young people and women. These services include specialist hospital and community clinic-based services as well as universal and targeted ones. The three constituent Directorates of the Clinical Board are Children's Hospital for Wales, Children, Young People and Family Health Services and Obstetrics & Gynaecology.

We have concluded **reasonable** assurance on this area. Matters requiring management attention include:

- There was an absence of Terms of Reference documents for core/key Clinical Board and Directorate governance meetings.
- It was evidenced that core/key Clinical Board and Directorate governance meetings were cancelled and there was an absence of minutes for some meetings.

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

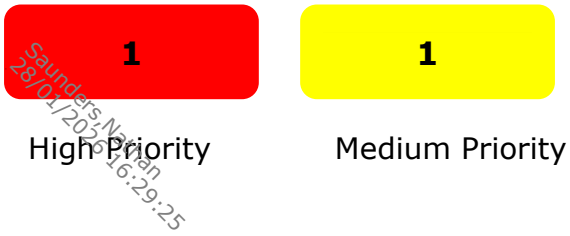
The following opportunities for enhancement have also been identified that do not impact upon the overall opinion, and are highlighted for management information:

- Training should be undertaken in financial and budgetary management principles to provide new and existing budget holders with the necessary skill set to effectively understand and manage their budgets.
- Future annual costs savings scheme planning processes and outcomes should be documented and signed off at Directorate Management level to provide a formal record of the decision making undertaken.

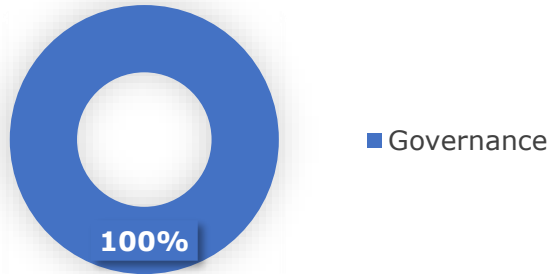
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	An appropriate governance structure is in place within the Clinical Board including all required groups, aligned to the Health Board's committee structures, and directed by a Terms of Reference (ToR)	1	**Reasonable**
2	Adequate governance arrangements are in place with meetings being conducted in line with ToRs and notes or minutes being maintained that provide a record of the key discussions and decisions made during the meetings	2	**Reasonable**
3	The Clinical Board works collaboratively with their Finance Business Partners to manage their financial budgets, and the financial position is presented and discussed at appropriate meetings and actions are taken to address identified issues	-	**Substantial**
4	Appropriate savings plans are developed as part of the Clinical Board's Quality Improvement & Efficiency Plan (QIEP) and implementation of agreed savings plans are monitored, reported and acted upon at Clinical Board level, and risks to achievement of savings targets are identified.	-	**Reasonable**

Management Actions



Themes



Risk Types

Quality or Safety Issues

8.6 Financial Sustainability – Temporary Staffing Controls

Reasonable Assurance

Purpose

The overall objective of the audit was to review how the Health Board deploys its workforce to ensure effective and efficient utilisation of the substantive resource, and limitation of the use of temporary staffing, including overtime, bank and agency costs.

Financial sustainability is a critical pillar of effective governance and long-term service delivery in the NHS. For the Health Board, the ability to maintain financial balance while meeting the complex and evolving health needs of its population is both a statutory obligation and a strategic imperative. In the current climate of constrained public finances, rising demand, and increasing operational costs, the importance of robust financial planning, control, and assurance mechanisms cannot be overstated.

The Health Board is currently forecasting a deficit of £56.2 million for 2025/26, significantly above the Welsh Government's control total of £9.1 million. This position reflects a combination of structural financial challenges, including an underlying deficit, inflationary pressures, and the need to deliver substantial recurrent savings. The Health Board's Corporate Risk Register and Board Assurance Framework both highlight financial sustainability as a red-rated risk, underscoring the urgency of effective mitigation and oversight. Despite the implementation of enhanced controls, including a themed savings programme and a daily Programme Management Office the scale of the challenge remains significant.

The underlying deficit remains a critical concern and is projected to worsen in 2026/27 without the delivery of recurrent savings. Key operational cost pressures include:

- Mental health out-of-area placements,
- Underperformance in cardiac and critical care contracts,
- Banding arrears for resident doctors,
- Continuing Healthcare (CHC) costs,
- National Insurance underfunding (15% impact, approx. £1.4 million),
- Risk Pool liabilities (approx. £6.6 million exposure),
- Band 2–3 corrective payments (potential £5.8 million risk).

To mitigate these pressures, the Board approved a vacancy freeze from August 2025, with only service critical posts being approved aligned to level of risk, with potential in-year savings of up to £4.2 million.

Overview

We have concluded **Reasonable** assurance on this area. The significant matters requiring management attention include:

- Medical & Dental Bank - Patchwork system data analysis revealed issues in medical and dental bank shift usage, including long lead times and concentrated approval patterns, indicating potential weaknesses in resource/operational workforce planning and governance.
- The Programme Management Office (PMO) was implemented from January to April 2025, its role in cost containment was unclear, with no demonstrable financial impact.
- Reporting structures are well-established, but data limitations hinder full visibility and operational workforce planning.

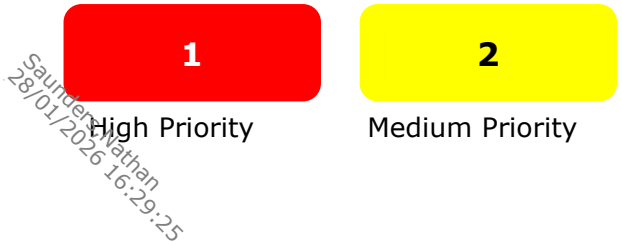
While controls are generally well-designed and operating with some effectiveness, further improvements are needed in medical and dental workforce planning and governance to fully realise financial sustainability objectives.

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

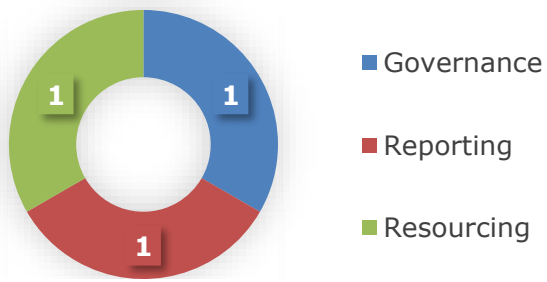
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Effective controls are in place over temporary staffing expenditure, including agency, bank, and overtime usage	1	**Reasonable**
2	Comprehensive governance and oversight arrangements in place to monitor temporary pay trends and cost drivers	3	**Reasonable**
3	The temporary financial control measures introduced in 2025 were effective and had a positive impact on workforce deployment, agency spend, and overall cost containment	2,3	**Reasonable**
4	Comprehensive and timely reports on bank, agency and overtime expenditure are produced and disseminated to relevant staff and groups across the Health Board. These reports are actively monitored and challenged to support informed decision-making and ensure effective financial oversight	2	**Reasonable**

Management Actions



Themes



Risk Types

Quality or Safety Issues

Financial Loss

8.7 Quality & Safety Governance

Advisory

Purpose

Our advisory audit of the Health Board's Quality & Safety Governance Arrangements has been completed as an addition to the 2025/26 internal audit plan for Cardiff and Vale University Health Board, following a request from the Health Board's Chair and Chief Executive.

Prior to this audit, a comprehensive internal review of theatre services was undertaken at the University Hospital of Wales (UHW) Theatres after evidence surfaced of a number of issues. That review commenced on the 24 October 2024, focusing on the following key themes:

- Values and behaviours;
- Leadership and management capability;
- UHW theatres leadership structure and roles and responsibilities;
- Team dynamics;
- Communication and engagement;
- Fairness and equity; and
- Staff turnover.

The review's findings were presented to the Chief Operating Officer on the 7 May 2025, outlining 66 recommendations under the above themes, with patient and staff safety and experience and theatre efficiency themes also being incorporated into the review. There were six recommendations that required immediate action.

The review highlighted a number of concerning themes, including leadership failures, inconsistent adherence to policies and procedures, and poor culture. In addition, it also revealed that governance and oversight of theatres within the Surgical Clinical Board and the broader organisation had been insufficient.

Following a Service of Concern meeting with the Health Board on 12 May 2025, Health Inspectorate Wales (HIW) also requested that the Health Board demonstrate how it has considered the overall governance processes in place.

Following the review and the request from HIW, a number of actions were agreed to be undertaken, including commissioning Audit and Assurance to undertake a review of the Health Board's quality and safety governance in order to evaluate the effectiveness of the current arrangements.

The Audit has primarily focussed on the Medicine and Surgery Clinical Boards, while also reviewing the wider corporate quality and safety governance arrangements within the Health Board.

Overview

The Health Board's corporate policies and procedures were reviewed, and discussions were held with key individuals in order to establish and evaluate the centralised quality and safety governance processes that are in place. Observations in relation to Clinical Board, directorate and speciality level

quality and safety governance arrangements have been derived from our enquiries within the Medicine and Surgery Clinical Boards along with the examination of minutes, terms of reference and other documentation relating to the various quality and safety groups operating within them.

The breadth of scope of quality and safety governance arrangements in a Health Board setting necessitates a multi-faceted and stratified approach involving a wide range of stakeholders. This review has focused on the core governance arrangements, and as such, some supporting processes may be in place that have not been captured.

Overall, we found that established Quality & Safety governance arrangements are in place within the Health Board. Reporting arrangements have frequently been documented, although some inconsistencies were identified in the regularity of reporting, and the reporting processes in some areas had not been clearly defined.

Although quality and safety groups are operating appropriately and relevant staff are engaging with governance processes, a paucity of central guidance has contributed to some inconsistencies in the management and administration of groups at speciality and directorate levels. Quality and safety leads have been nominated across many specialities and directorates and at the Clinical Board level, but the roles and responsibilities of leads have not been clearly defined in all cases. There is no central register of quality and safety groups or leads, and it is not clear if there has been sufficient oversight to ensure the groups operate consistently and are mutually supportive.

Feedback from relevant staff members indicated that a good level of awareness exists with regard to quality and safety reporting processes, but there is a lack of clarity around the means by which issues are escalated once they have been reported.

The conclusions of this review would indicate that, notwithstanding some shortcomings in administrative matters, there are generally sufficient resources and expertise being dedicated to the quality and safety governance processes within the Health Board, which are often well established and operate effectively. However, significant benefits are likely to be derived from the production and dissemination of more detailed guidance, and the implementation of some centralised processes to ensure a greater degree of consistency in the management of groups.

As this is an advisory review no assurance rating is provided. The following opportunities have been identified that the Health Board may wish to take forward in order to strengthen processes:

- Inclusion of target dates in relation to escalation framework actions.
- Production of a comprehensive structure chart to illustrate the quality and safety governance arrangements within the Health Board.
- Establishing a register of quality and safety groups and compiling a list of quality and safety leads.
- Production of guidance for Clinical Boards and Directorates.
- Ensuring the regularity of reports to the Quality Committee.
- Co-ordination of meeting frequency and scheduling between the tiers of the governance hierarchy.
- Provision of support to Clinical Boards in ensuring all relevant areas are encompassed by the quality and safety governance arrangements.
- Production of Terms of Reference, and implementation of contingency measures to mitigate the impact of shortcomings in administrative support resources.
- Production of supporting guidance for staff.

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

Advisory Scope Summary

Objectives		Related Actions
1	Establish and evaluate the current Quality & Safety Governance arrangements operating within the Health Board	1
2	Are the current arrangements clearly documented within relevant policies / procedures and are they readily available / known across the organisation	2, 3, 4
3	Do the arrangements allow for a clear and timely route of reporting, escalation and assurance from ward and service areas up to the Board	5, 6
4	Are the processes within the Clinical Boards operating in accordance with the stated policies / procedures	7, 8
5	Do key management and clinical staff within the Clinical Boards have a good knowledge and understanding of the processes and what they should do if they become aware of an issue	9

Management Actions

9

Themes

- Performance Monitoring
- Quality, Safety & Patient Experience
- Information, Data Quality & Data Accuracy
- Policies & Procedures
- Reporting
- Planning, Delivery & Deadline Management
- Resourcing
- Communication & Engagement

Risk Types

Quality or Safety Issues

8.8 Follow-Up: Implementation of the Health Roster System

Assurance Not Applicable

Purpose

We have completed a second follow-up review of 'Implementation of Health Roster System'.

Our original Implementation of Health Roster System audit was reported in November 2023 and identified nine issues and resulted in an overall assurance rating of 'Limited Assurance'.

A follow-up review was subsequently completed during 2024/25 to verify the progress that had been made in implementing the recommendations and agreed management actions. Our report was finalised in January 2025 and concluded that, of the nine recommendations, four remained open, and we therefore issued a further 'Limited Assurance' opinion due to the significance of the actions still to be fully implemented.

For 2025/26 we have revised our approach to reporting our follow-up audit work to ensure that we comply with the requirements of the new Global Internal Audit standards. As such we will no longer be providing an assurance rating as part of our follow-up reports.

The purpose of this current and second follow up review is therefore to establish if management has now taken corrective measures to fully implement the remaining four actions and address the relevant key findings from our original report.

We note that the Audit and Assurance Committee has continued to monitor progress in implementing these actions through the internal audit tracker.

Overview

Our follow up review of the four agreed actions has identified the following:

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	2	0	1	0
Medium	1	1	1	0
Low	1	1	0	0
Total	**4**	**2**	**2**	**0**

Full details of the agreed actions requiring further work are provided in the table below. We have re-assessed the priority ratings for the actions and these have been adjusted where appropriate.

For the agreed actions that have been closed, management have undertaken work to address the key findings in our original report. This includes:

- **The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality. (AMaT ref: 2025/257/MD4)**

  The original audit highlighted very low usage of the auto-rostering functionality (15%), despite its availability across all areas. The first follow-up noted that uptake remained low but showed an improving trend, with 38% of all rosters using the functionality. Our current follow-up confirms that the feature remains enabled within HealthRoster. System data analysis indicates a positive uptake trend to 49%, an increase of 11% since the previous follow-up, bringing the Health Board close to its target of 50% auto-rostered rosters.

  To support this improvement, Clinical Board Directors have instructed all areas to update Work Life Balance (WLB) agreements and liaise with the E-Rostering Team. Engagement efforts include targeted training sessions for roster managers, one-to-one support to address local challenges and policy updates clarifying expectations and compliance requirements. Evidence was reviewed including system configuration screenshots, communications, and logs of WLB updates that confirms these actions. Uptake has improved since the original audit, and ongoing engagement and system refinements are planned to drive further progress.

- **E-Rostering team need to continue to work with Corporate Nursing to ensure that staff balances are being managed adequately. (AMaT ref: 2025/257/MD5)**

  The original audit identified significant issues with managing time balances and hours owed. Our first follow up identified that whilst this was still an issue positive trends were noted and the recommendation was downgraded from high to low priority. During the current follow-up work we noted substantial improvement in this area. Weekly and monthly reports now provide detailed visibility of net hours owed, broken down by Clinical Board, Directorate, and service area. These reports are reviewed at the Nursing Productivity Group (NPG) and escalated to the Executive Director of Nursing where necessary. Evidence from time balance reports and NPG agendas confirms that performance management is embedded and that corrective actions are taken promptly when variances occur. While fluctuations occur—particularly around payroll cut-off dates—these are understood and managed effectively. Trend analysis is being developed to monitor month-on month and year-on-year improvement, further strengthening assurance.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2024/25 Plan							
Medicine CB Acute Medicine Model	35	Chief operating Officer	1		Final Report	Reasonable	September
2023/24 Plan							
Integrated Annual Plan	13	Finance	1		Final Report	Reasonable	September
Cyber Security	04	Digital Health & Intelligence	1		Final Report	Reasonable	September
Deprivation of Liberties Safeguards (DoLS)	16	Nursing	1/2		Final Report	Reasonable	November
GMS Unified Contract Assurance Framework	28	Chief operating Officer	2/3		Final Report	Substantial	February
ALN Act	08	Allied Health Professionals	3		Final Report	Reasonable	February
Medical Equipment & Devices	09	Allied Health Professionals	2/3		Final Report	Reasonable	February
Standards of Business Conduct	02	Corporate Governance	3/4		Final Report	Reasonable	February
Children and Women Clinical Board Governance and Financial Arrangements	25	Chief Operating Officer	2		Final Report	Reasonable	February
Financial Sustainability – Temporary Staffing Controls	10	Finance	2		Final Report	Reasonable	February
Quality & Safety Governance	34	Chief Exec / Chairman	1		Final Report	Advisory	February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Implementation of Health Roster Follow-up	15	Nursing	2/3		Final Report	N/A	February
Digital Literacy	07	Digital Health & Intelligence	2/3		Draft Report	Advisory	May
Medical Staff Deployment	31	Medical	1		Work in Progress		May
Clinical Board Adherence to the Managing Attendance at Work Policy	18	People & Culture	1/2		Work in Progress		May
Staff Overpayments	11	Finance / People & Culture	3		Work in Progress		May
Neurodevelopment Services for Adults and Children	27	Chief Operating Officer	4		Work in Progress		May
Flexible Working Arrangements for Compressed and Variable Hours	36	COO / People & Culture	4		Work in Progress		May
Alcohol Standards Follow-up	03	Public Health	4		Work in Progress		May
Estates Assurance – Space Utilisation	14	Finance	2		Planning – Final brief issued		May
Reducing Health Inequalities	22	Public Health	3		Planning – Final brief issued		May
Occupational Health	20	People & Culture	3		Planning – Final brief issued		May
Follow-ups not booked	30	Chief operating Officer	~~2~~	3	Planning – Final brief issued		May
Performance Management	29	Chief operating Officer	3/4		Planning – Final brief issued		May
AI – Use of Robotics and Automation	05	Digital Health & Intelligence	3/4		Planning – Final brief issued		May
Leadership and Management Training / Development	19	People & Culture	3/4		Planning – Final brief issued		May

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Planned Care Programme	26	Chief Operating Officer	3/4		Planning		May
Medicines Management	32	Medical	3/4		Planning – Draft brief issued		May
5 Steps to Safer Surgery	33	Medical	~~2/3~~	4	Planning – Final brief issued		May
Risk Management and Board Assurance Framework	01	Corporate Governance	4		Planning – Final brief issued		May
Local / Shadow IT Systems	06	Digital Health & Intelligence	4		Planning – Final brief issued		May
Decarbonisation Follow-up	12	Finance	4		Planning – Final brief issued		May
Nurse Staffing Levels	17	Nursing	4		Planning – Draft brief issued		May
Interventions Not Normally Undertaken Follow-up	21	Public Health	4		Planning – Draft brief issued		May
Approved Integrated Audit & Assurance Plan Assignments:							
Wellbeing Hub Park View	SSU	Finance	2		Draft Report	Limited	May
Pentyrch/Rhydlafar ICRF Health Centre	SSU	Finance	4		Work in Progress		May

Reviews removed from the plan

CD&T CB – Governance Arrangements	24	Chief Operating Officer	Replaced by advisory review of Quality & Safety Governance. Agreed by September AC.
Diabetes Care Process	23	Public Health	Proposed for deferral from the 25/26 plan due to ongoing introduction of new processes. To be agreed by November AC.

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Cyber Security	Limited	Final	04/08/25	26/08/25	14/08/25	15/08/25	G
Integrated Annual Plan	Reasonable	Final	25/07/25	15/08/25	15/08/25	18/08/25	G
Medicine Clinical Board – Acute Medicine Model	Reasonable	Final	07/08/25	29/08/25	20/08/25	20/08/25	G
Deprivation of Liberties Safeguards	Reasonable	Final	19/08/25	10/09/25	10/09/25	10/09/25	G
ALN Act	Reasonable	Final	10/11/25	01/12/25	01/12/25	02/12/25	G
Medical Equipment & Devices	Reasonable	Final	28/10/25	18/11/25	08/12/25	09/12/25	R
Standards of Business Conduct	Reasonable	Final	09/12/25	02/01/26	17/12/25	17/12/25	G
Children and Women Clinical Board Governance and Financial Arrangements	Reasonable	Final	20/11/25	11/12/25	19/12/25	19/12/25	R
Financial Sustainability – Temporary Staffing Controls	Reasonable	Final	15/12/25	08/01/26	21/12/25	22/12/25	G
GMS Unified Contract Assurance Framework	Substantial	Final	14/01/26	04/02/26	21/01/26	21/01/26	G
Quality & Safety Governance	Advisory	Final	07/11/25	28/11/25	14/01/26	21/01/26	R
Implementation of Health Roster Follow-up	N/A	Final	13/01/26	03/03/26	21/01/26	21/01/26	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	May 2025	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	R	56% 9 from 16	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 14 from 14	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75% 9 from 12	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 12 from 12	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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.

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Archwilio Cymru
Audit Wales

Cardiff and Vale University Health Board – Audit and Assurance Committee Update

Date issued: January 2026

Contents

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Introduction

This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in April 2025.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2024-25 Health Charities Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2024-25 Health Charities Annual Report and Accounts
- **Status:** Audit complete and unqualified opinion provided 22 January 2026
- **Expected committee date:** January 2026 (Board of Trustees)

Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Planning work ongoing
- **Expected committee date:** June 2026

Performance audit update

Structured assessment 2025 – core

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment reviewed:
  - Board and committee cohesion and effectiveness;
  - Corporate systems of assurance;
  - Corporate planning arrangements; and
  - Corporate financial planning and management arrangements.
- **Status:** Complete – final report in today's papers.
- **Expected committee date:** February 2026

Review of eye care services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work assessed the Health Board's eye care services including plans to meet current and future population needs, regional working and arrangements to improve service efficiency. The review also considered how the Heath Board is supporting patients to minimise the risk of harm occurring as a result of delays in access.
- **Status:** Complete – final report in today's papers.
- **Expected committee date:** February 2026

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Fieldwork in progress
- **Expected committee date:** May 2026

Progress review: 2019 Clinical Coding Follow-up Review

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will focus on reviewing the Health Board's progress in addressing the recommendations made in our 2019 clinical coding follow-up review, which was a follow-up of the work completed in 2014.
- **Status:** Fieldwork in progress
- **Expected committee date:** May 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Fieldwork in progress
- **Expected committee date:** May 2026

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider:
  - The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
  - The efficacy of local plans and associated actions to recover cancer waiting lists; and
  - Use of the additional Welsh Government financial allocations to improve cancer services.
- **Status:** In progress – project brief issued January 2026
- **Expected committee date:** September 2026

Other relevant publications

Since the last committee update, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

Checking the patients. Results from a pilot data matching exercise on GP patient lists	January 2026
Positive action on fraud and error in community pharmacy but more analysis could reap rewards (news article)	December 2025
Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028	December 2025
Facing the Future – Auditor General for Wales Podcast – Episode 4	November 2025
Opportunities for Change – Auditor General for Wales Podcast – Episode 3	November 2025
Under Pressure – Auditor General for Wales Podcast – Episode 2	November 2025
A Unique Perspective – Auditor General for Wales Podcast – Episode 1	November 2025

Since the last committee update, Audit Wales has also published the following corporate document.

Fee Scheme 2026-27	January 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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Archwilio Cymru
Audit Wales

Structured Assessment 2025

Cardiff and Vale University Health Board

December 2025

About us

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Contents

Audit snapshot

What we looked at

1 We looked at how well Cardiff and Vale University Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:

- how it produces key plans and strategies
- how well its board works;
- how it keeps track of risks, performance, service quality, and recommendations; and
- how it manages its finances.

2 We also looked at the Health Board's progress in implementing recommendations from:

- previous structured assessment reports; and
- our 2024 report on cost savings.

3 We did not look at the Health Board's operational arrangements.

Why this is important

4 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

5 The Health Board has demonstrated an inclusive approach for developing its Annual Plan, supporting delivery of its long-term strategy. It is accelerating work on its Clinical Services Plan and improving Board-level reporting on Annual Plan delivery. However, strategic portfolios require well-defined delivery roadmaps and stronger committee oversight.

6 The Board and committees continue to work well, remaining committed to public transparency and hearing from patients and staff. Whilst the Board has continued to experience significant turn-over this has been well managed. However, the absence of an Independent Member for finance presents a risk. Opportunities remain to enhance Board and committee papers and effectiveness reviews.

7 The Health Board continues to strengthen and digitalise systems of assurance. However, there is still a need to improve risk and performance management, and to strengthen aspects of quality and safety monitoring and recommendation tracking.

8 The financial position remains a significant concern, with a forecast year-end deficit of £56.2 million against a £9.1 million control total. Although the Health Board has identified all planned savings, there is still a £5.3 million shortfall against its recurrent savings target. As in previous years, it was unable to submit a financially balanced three-year Integrated Medium-Term Plan to Welsh Government. Work to develop a long-term financial model remains at an early stage.

What we recommend

9 We have made ten recommendations to the Health Board, which focus on:

- Improving committee oversight of strategic portfolios;
- More frequent reporting on policies overdue for review;
- Enhancing Board and committee papers by focusing on key issues and impact;

- Enhancing Board and committee effectiveness reviews;
- Developing a Performance Management Framework;
- Strengthening aspects of quality and safety monitoring; and
- Clarifying Quality Improvement and Efficiency Plan reporting at Board level.

Key facts and figures

The Health Board is at Level 4 for all six areas under the Welsh Government's escalation and intervention arrangements.

The Health Board does not have an approved Annual Plan for 2025-26 or an Integrated Medium-Term Plan that is approvable by Welsh Government.

The Health Board did not meet its financial duty to breakeven on its revenue spend in 2024-25 and over a three-year period, reporting a three-year cumulative deficit of £70.8 million.

In 2024-25, the Health Board delivered £34.5 million in savings, against a target of £47.2 million. Its 2025-26 savings target is £32 million. At month seven, it has delivered £13.9 million of savings.

The Health Board is forecasting a year-end deficit of £56.2 million, against a Welsh Government 'control total' expectation of £9.1 million.

The Health Board has fully implemented six outstanding recommendations since our last structured assessment report, nine are still in progress, five have been superseded by new recommendations and there has been no progress against one.

Our findings

Preparing strategies and plans

Arrangements for developing and overseeing the Annual Plan are reasonable, and the Health Board is progressing its Clinical Services Plan. However, strategic portfolios require well-defined delivery roadmaps and stronger committee oversight.

Producing key strategies and plans

10 Since its refresh in 2023, the Health Board has been working to operationalise its long-term strategy. It now has a clear strategic framework, which aligns its strategic/well-being objectives, change portfolios, risks and committees. This ensures governance structures support the delivery of its long-term strategy. The Health Board is currently working with an external consultant to redesign its operating model to better support its strategy. The discovery phase, which reviewed the current model, is complete and the design phase started in December 2025.

11 Last year the Health Board agreed governance arrangements to oversee its six strategic portfolios[1]. While slow to start, all Strategic Portfolio Boards are now in place and by August 2025 had met at least once. The 2025-26 Annual Plan outlines immediate, short-term priorities for each portfolio. These focus on ensuring the Health Board has the systems, processes and infrastructure to support sustainable change. However, as yet, the portfolios do not have well defined medium-term roadmaps for delivery.

[1] Shaping Our Future People and Culture; Shaping Our Future Population Health and Places; Shaping Our Future Quality and Value; Shaping Our Future Clinical Services; Shaping Our Future Infrastructure and Shaping Our Future Generations.

12 The Health Board's strategic objectives also act as its well-being objectives. In 2023, we found that while these objectives have clear priorities, they do not fully address all aspects of sustainable development, such as biodiversity and climate adaptation. The Health Board plans to address this through its Shaping Our Future Generations Strategic Portfolio.

13 In July 2025, Welsh Government escalated the whole Health Board to Level 4 (Targeted Intervention), due to concerns across all areas in the escalation and intervention framework. The Health Board and Welsh Government are working to agree criteria for de-escalation.

14 Developing a Clinical Services Plan is a key requirement for de-escalation. This plan will define the Health Board's 10-year strategic vision for clinical services and is due to be launched in March 2026. The Health Board is running a series of community engagement activities between August–December 2025, with feedback informing the plan. While positive, timescales for the plan's development are ambitious.

15 The Health Board is currently working to an Annual Plan, as it was unable to submit a financially balanced Integrated Medium Term Plan (IMTP) to Welsh Government. The Annual Plan does not meet the financial requirements set by Welsh Government so remains unapproved by them. We discuss the Health Board's financial position in more detail in **paragraph 65**.

16 The Health Board engaged well with the wider organisation in developing its Annual Plan for 2025-26, working collaboratively with clinical boards and corporate teams. This included a Rapid Planning Event with around 200 leaders in December 2024 and Board engagement at key stages. In September 2025, Internal Audit issued a Reasonable Assurance report on the process for developing this year's plan. The Health Board's ongoing financial challenges limited the rating to reasonable assurance.

17 The Health Board completed Welsh Government's planning maturity self-assessment, reporting the outcome to the Board and Finance and Performance Committee in November 2025. Across six areas, the Health Board scored itself at either level one or two[2] (with level five being exemplar). Using these insights, the Health Board has developed an improvement plan to help them improve to the next level. The Finance and Performance Committee will oversee the plan, with the majority of actions due for completion this financial year.

Monitoring delivery of strategies/plans

18 The 2025-26 Annual Plan includes a clear delivery plan, and the Health Board is working to strengthen Board level reporting. For each strategic portfolio, the plan outlines key actions for 2025-26, quarterly measures of success, and high-level areas of focus for 2027 and 2028. It also specifies which long-term strategic milestones each portfolio supports.

19 In common with other NHS bodies in Wales, the Health Board faces a challenge with monitoring a wide range of national and local actions and targets. The Annual Plan has approximately 200 deliverables, making tracking complicated. However, the Health Board has an ambition to develop a single integrated dashboard to support monitoring. As part of the 2026-27 planning cycle, the Health Board is reviewing its Annual Plan deliverables with a view to rationalising them.

20 The Board and the Finance and Performance Committee currently receive high-level updates on strategic portfolios via the Strategic Planning, Commissioning and Partnership report and the recently reinstated quarterly Annual Plan delivery updates. However, in-depth oversight and scrutiny of portfolio programmes and projects is limited. To strengthen oversight arrangements, each committee should receive routine progress updates aligned with their respective strategic portfolio.

[2] Strategy and plan development (Level 2), strategy, plan alignment and development of IMTP (Level 1), dynamic and engaged planning (Level 2), operational planning (Level 2), best practice approach to improvement (Level 2) and realistic and deliverable (Level 2).

Board assurance on partnership working

21 The Board has good arrangements for receiving assurance on partnership working at local, regional and partnership level. For example, its routine Strategic Planning, Commissioning and Partnership report includes updates on the Regional Partnership Board and the Regional and Specialised Services Provider Planning Partnership[3].

22 In April 2025, Welsh Government instructed the Chairs of Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards to establish a South-East Wales Regional Joint Committee. In September 2025, the Board approved the establishment of the Committee, its terms of reference and operating arrangements. The first meeting took place in November 2025.

23 Our recent eye care review across each of the health boards in the south east Wales region shows that whilst some progress is being made, the intended benefits of regional working are yet to be fully achieved and complex governance structures can make decision-making slow and cumbersome.

Board effectiveness and openness

The Board and committees continue to work well, with an improved Board walkabout process. Scope remains to enhance papers and effectiveness reviews

Public openness of board business

24 The Board maintains its commitment to public transparency by ensuring:

- members of the public can watch Board and committee meetings, via a livestream or recordings uploaded promptly to the Health Board's website after meetings;

[3] This is a partnership with Swansea Bay University Health Board.

- Board and committee[4] papers are available on the Health Board's website five days before meetings;
- private Board and committee meetings are held only for sensitive matters, such as legal issues or commercially confidential topics;
- private agendas continue to be made available publicly; and
- the Board holds difficult discussions in public, for example about its critical report on theatre services and its increased escalation status.

25 However, while Board meetings are livestreamed and recorded the sound quality is often poor. To address this issue, from November 2025 Board meetings will be held online, with the option to hold meetings in person as needed.

26 The Health Board is reviewing its Health Professionals Forum and Stakeholder Reference Group; as a result, both are currently paused. The Local Partnership Forum continues to meet regularly, with papers published online after minutes are ratified, resulting in a time lag before they appear online.

Supporting effective board conduct

27 The Health Board has good arrangements to support the Board and its committees to run effectively. It maintains up to date Standing Orders, Scheme of Reservation and Delegation and Standing Financial instructions. The Board reviews these at least annually to ensure they reflect current arrangements.

28 In January 2025, Internal Audit issued an advisory report on the Health Board's decision-making process. The review highlighted an opportunity to simplify the Scheme of Delegation and Earned Autonomy Framework; this work is planned as part of work to redesign the operating model.

[4] The Health Board does not publish papers for its Remuneration and Terms of Service Committee due to their confidential nature.

29 The Health Board has good arrangements to promote probity and propriety, supported by an up-to-date Standards of Behaviour Policy. Its Register of Interest is published on the website. Audit and Assurance Committee oversee these arrangements through an annual declaration of interest assurance report. While Board Members continue to declare their interest annually, the Corporate Governance Team is working to improve staff compliance with declarations of interest[5]. Declarations of interest remain a standing item on all Board and committee agendas.

30 The Health Board uses the Audit Management and Tracking (AMaT) system to keep track of policies which are due for review. In May 2025, of the 415 policies on AMaT, 234 were overdue for review highlighting the need for continued focus in this area. Progress is reported annually to the Audit and Assurance Committee. Given the volume of policies overdue for review, the Audit and Assurance Committee should receive more frequent progress updates.

Assurance on Joint Commissioning Committee effectiveness

31 The Joint Commissioning Committee (JCC) was established in April 2024 as a joint committee of the seven health boards in Wales. The JCC plans and commissions a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven health boards.

32 As part of this year's structured assessment, we reviewed whether the Board is receiving the right level of assurance on JCC business, as well as the Health Board's involvement in JCC meetings and activities. We found that the Board, Quality Committee and Finance and Performance Committee receive routine assurance on the work of the JCC and its sub-groups.

33 In May 2025, the JCC Chair, Chief Commissioner, and Transformation Director delivered a presentation to the Board, providing an overview of the committee's work.

[5] As at May 2025, 75% of staff were yet to update their declarations of interest on the Electronic Staff Record (ESR). Compliance with staff declarations of interest, along with ensuring policies and risks are kept up to date, is now included in the clinical board executive performance reviews.

Board and committee meeting effectiveness

34 Last year, the Board approved changes to committee arrangements to ensure the committee structure aligns more closely to the organisation's strategic objectives, portfolios and risks. The changes were implemented in January 2025; the biggest change was setting up a new Digital and Infrastructure Committee, which replaces the Digital and Health Intelligence Committee. While these arrangements are embedding, stronger oversight of strategic portfolios is still needed (**see paragraph 20**).

35 Board and committee meetings remain well chaired, with active independent member participation. In response to financial and performance challenges, all independent members sit on the Finance and Performance Committee. We have seen increased scrutiny and challenge in recent months. While meetings are well chaired overall, some chairs focus too heavily on time keeping. This can make some meetings appear rushed, especially when the agenda is large, potentially limiting discussion on certain items.

36 Papers to the Board and its committees continue to be of good quality. They are assisted by the consistent use of cover sheets that prompt for alignment to the refreshed strategic objectives, and 'supporting documents' folders which aim to keep the volume of papers manageable. The format of several routine reports[6] have been updated this year making them clearer, more data focused and engaging.

37 However, for some reports, it is difficult to identify the key issues and where members should focus their attention. Reporting could be improved by using a format like 'Alert, Advise, Assure', which clearly sets out:

- Areas of concern where actions are not delivering impact (Alert),
- Areas where actions are starting to make a difference (Advise), and
- Areas performing effectively (Assure).

[6] The format of the Quality Indicators Report, Integrated Performance Report cover paper, and Finance Report have been updated.

38 This would help ensure discussions are targeted in the right areas and increase focus on the impact of actions being taken. We have seen this format being used successfully in other NHS bodies to strengthen Board assurance mechanisms, support cross-referral between committees and timely escalation of concerns to the Board.

39 All committees currently have terms of reference which were approved by the Board in November 2024. We note that the Health Board intends to review committee terms of reference as part of its review of the scheme of delegation. However, it is important that this process supports timely review to ensure terms of reference accurately reflect the work committees need to undertake. For example, reflecting new quality governance arrangements once agreed (**see paragraph 57**). While both the terms of reference and forward workplans are publicly available, the workplans are not updated on the website in a timely manner.

Hearing from staff and service users

40 The Board remains committed to hearing from patients and staff, using a range of methods such as:

- the Board, Quality Committee and People and Culture Committee hear regular patient and staff stories;
- the Quality Indicators Report includes updates on patient experience; and
- the Clinical Services Plan consultation is using a wide range of methods to reach a diverse group of citizens.

41 Since last year, the Health Board has clarified the process and purpose of its patient safety walkarounds. In August 2025, it launched 'Leaders who Listen'. This is wider than Board Members visiting services and includes clinical board leadership walkabouts and learning and feedback mechanisms. While it is too early to comment on its effectiveness, it is a positive step forward. A quarterly report identifying key themes and learning will feed into both the People and Culture, and Quality committees.

42 The Health Board has strengthened its ‘Speaking Up Safely’ process by launching an anonymous platform, Work in Confidence. It has also trained volunteer connectors, to help staff raise concerns and access support without bias. The People and Culture Committee receive updates on the concerns raised, emerging themes and work to promote the system. The Health Board plans to integrate the process into wider quality improvement processes, to identify issues early and build trust. This is important given recent internal and external reviews highlighting cultural and behavioural concerns.

Board cohesion and continuous improvement

43 The Board has seen a lot of change in recent years. Since our last structured assessment, the executive team has been relatively stable, with only the Executive Director of Strategic Planning role covered on an interim[7] basis. A permanent appointment has now been made, with the new Executive Director of Strategic Planning expected to start in April 2026.

44 There has been significant turnover among Independent Members. This year, the independent members for community, third sector, finance, and the Chair of the Board came to the end of their terms. This follows the appointment of three new independent members last year. This year, the Board welcomed new:

- Independent Member (Community) in June 2025,
- Chair of the Board in October 2025; and
- Independent Member (Third Sector) in October 2025.

45 However, the Independent Member (Finance) position has been vacant since September 2025. While the Health Board is actively recruiting, this is a concern given the Health Board’s financial challenges. New members spoke positively of their induction process and the support received from the Board and Corporate Governance Team.

[7] The Executive Director of Strategic Planning role has been covered on an interim basis by the Executive Director of Finance since March 2024.

46 The Board remains committed to continuous learning and development through regular business and Board development sessions. The Board reserves part of its development sessions for strategic and performance discussions. It continues to set aside time for improvement and self-assessment work, which since October 2025, forms part of each Board development session. Topics this year have included, workplace resilience and wellbeing, and the roles and relationships between executive and independent members. Going forward, the Chair will include feedback from this work in her report to the Board.

47 Last year, we recommended that the Health Board evaluate and report on how its ongoing improvement activities are improving Board and committee working. In January 2025, the Board received a brief report detailing development activities, but not whether these activities have led to improvements. This recommendation still stands, particularly considering the new committee structure, independent members, committee chairs and developing strategic portfolios.

Providing board assurance

While the Health Board is strengthening systems of assurance, improvements are still needed in risk and performance management, oversight of quality and safety, and recommendation tracking

Managing strategic and corporate risks

48 The Board continues to receive the Board Assurance Framework (BAF) at every meeting, with the latest version publicly available in Board papers. Since last year, the Health Board has clarified committee oversight arrangements with most committees now routinely reviewing strategic risks aligned to their remit. However, given its wide remit, the Quality Committee is deciding how best to review its risks. These arrangements have been in place since the summer, so it is too early to assess their effectiveness.

49 While the Board receives the Corporate Risk Register (CRR) at each meeting, it is for information only and committee level oversight arrangements for corporate risks is still not clear. This means there is little Board-level oversight of the CRR.

50 Our findings are consistent with an Internal Audit review of risk management arrangements and BAF. The reasonable assurance report issued in May 2025, made two high and three medium priority recommendations. These focused on the overdue risk management strategy and risk appetite review, oversight of strategic and corporate risks and implementing the AMaT system risk module. The Audit and Assurance Committee is due to consider the new risk management policy for approval in February 2026.

51 Much of the Health Board's risk management improvements are reliant on fully implementing the AMaT risk management module. However, this is still a work in progress. By the end of October 2025 all corporate risks were on AMaT and the Health Board is aiming to upload all operational risk registers by the end of the current financial year[8].

Managing performance

52 Since 2022, we have highlighted the Health Board's lack of an up-to-date Performance Management Framework (PMF). The framework, which was approved in 2020, is outdated as the Health Board has since refreshed its long-term strategy, changed its committee structure, updated operational performance management arrangements and been escalated. Developing a new PMF is essential to clarify roles, responsibilities and accountability arrangements to support performance improvement.

53 The Board continues to receive the Integrated Performance Report (IPR) monthly. The IPR cover report has been updated to a more engaging, slide-style presentation. The report is less detailed, but officers provide detailed verbal updates and, when requested further information on specific metrics.

54 However, there are still opportunities to strengthen the IPR by:

[8] To date over 750 risks have been added to the AMAT system.

- the cover report using the Alert, Advise, Assure format to have a greater focus on the impact of actions (**see paragraph 37**);
- aligning the IPR with the strategic portfolios, instead of the quadruple aims, to make Annual Plan and strategy delivery more visible;
- including benchmarking data; and
- using the 'performance against standard' column consistently.

Monitoring quality and safety

55 The Quality Committee maintains oversight of the quality and safety of services. It continues to receive assurance through routine reports such as Quality Indicators and Clinical Board Assurance reports, as well as reports on topics such as nationally reportable incidents and internal and external service reviews.

56 The Health Board is progressing its Shaping our Future Quality Excellence Programme, with high-level updates included in the Quality Indicators Report. The programme has five projects, which focus on:

- Developing a Quality Management System,
- Reducing hospital acquired infections,
- Preventing patients becoming lost to follow-up;
- Improving management of acute deterioration; and
- Improving medication safety

57 As part of developing its Quality Management System, the Health Board is reviewing its quality governance arrangements. These are currently detailed in the 2021-26 Quality Safety and Experience (QSE) Framework. In addition, Internal Audit are currently reviewing the Health Board's quality and safety governance arrangements and are due to present their findings to the Audit Committee in February 2026.

58 The Quality Committee's terms of reference remain framed around the QSE framework, with responsibility for overseeing its implementation and receiving updates from several sub-groups. However, some groups are not reporting as intended. Such as the Learning Committee and the Clinical Safety and Concerns groups.

59 The Clinical Board Assurance and the Quality Indicators reports remain structured against the six pillars of quality[9], and the IPR includes some routine reporting on the Duty of Candour. However, there is no evidence that the Health Board has complied with the Duty of Quality requirement to produce an annual quality report for 2024-25. Nor could we see that it has included any commentary on how it is achieving its Duty of Candour within its annual reporting.

60 Reporting on clinical audit plans is limited. While the Health Board has an up-to-date Clinical Audit Policy requiring clinical boards and corporate audit plans to report to the Quality Committee twice a year, the Clinical Effectiveness Committee[10] only reports annually. Additionally, neither the Quality Committee nor the Audit Committee has received the clinical audit plan for review or approval.

Tracking and monitoring recommendations

61 The Health Board continues work to improve its audit and recommendation tracking processes, which it has been progressing since last year. It now routinely uses AMaT to manage Internal Audit and Audit Wales recommendations.

[9] The six domains of quality are defined by NHS Wales and are embedded in legislation through the Health and Social Care (Quality and Engagement) (Wales) Act 2022. They are; safe, timely, effective, efficient, equitable and person centred.

[10] The Clinical Effectiveness Committee is responsible for overseeing audit outcomes and improvement plans.

62 Work on the regulatory audit tracker is still ongoing. A review by the Corporate Governance Team found that processes to track recommendations from inspections and from other regulators' reviews are inconsistent, with gaps in escalation and assurance processes. The team is now working with relevant services to address these weaknesses, taking forward the actions presented to the Audit and Assurance Committee in November 2025 to improve arrangements. The team aims to complete this work by March 2027.

63 The Audit and Assurance Committee receive an Audit Tracker update three times a year. So far, reports focused mainly on internal audit recommendations due to delays in uploading Audit Wales recommendations to AMaT. This is now complete, and the November 2025 update highlighted that of the 46 open Audit Wales recommendations 28 are overdue.

64 In 2023, we recommended producing a report pulling together common themes, issues, and lessons from internal, external, and regulatory compliance reviews. However, the Audit Tracker update does not yet provide this analysis.

Managing finances

Despite financial oversight, control and management processes being in place, the Health Board's financial position remains extremely challenging

Meeting financial objectives and duties

65 The Health Board did not meet all its financial duties in 2024-25. Of the three duties, it met its capital resource limit, reporting an underspend of £0.244 million. However, it did not:

- spend within its revenue resource limit for the period 2022-25; and
- have an agreed three-year Integrated-Medium Term Plan for 2024-27.

66 The Welsh Government set the Health Board a target deficit of £9.1 million for 2024-25. The Health Board exceeded this, reporting a year-end deficit of £27.6 million. This is despite additional support of £6.8 million from Welsh Government.

67 The Health Board does not have a balanced financial plan for 2025-2026. In March 2025, the Board approved its Annual Plan for submission to Welsh Government, forecasting a deficit of £58.2 million. Welsh Government asked the Health Board to improve its financial plan. In response the planned deficit was reduced to £56.2 million, although this is still a long way short of the Welsh Government's £9.1 million control total target.

68 To manage operational overspends, the Board approved a full vacancy freeze (with exceptions) in August 2025. An enhanced recruitment scrutiny process, already in place, has begun to slow growth in workforce numbers. The Board also conducted deep dives with clinical boards to understand issues, assess risks, and gain assurance on actions needed to deliver within deficit control totals.

69 At month seven, the Health Board reported a year to date overspend of £35.6 million, £2.8 million above the planned deficit for the month. Despite being off track at month seven, the Health Board is still forecasting it will deliver its planned deficit of £56.2 million by year end.

Financial planning arrangements

70 The Health Board's financial planning approach remains integrated with its annual planning cycle. Last year the Health Board had started to develop a long-term financial model, however this work remains at a very early stage. In September 2025, the Finance and Performance Committee considered proposals for a 10-year financial model aligned to the Clinical Services Plan. However, no development timescales have been set yet. The paper highlights key challenges to developing the plan such as data quality, financial uncertainty, resource constraints, and shifting from a culture of short-term to long-term planning.

71 The Health Board has introduced a Quality Improvement and Efficiency Plan (QIEP) to replace the traditional savings plan. It aims to improve care quality, productivity, and efficiency while identifying capacity gains and cash-releasing savings. Each Clinical Board has its own QIEP, with reporting through executive performance reviews. However, Board level reporting is not visible, as savings continue to be reported as before.

72 In 2024-25, the Health Board delivered £34.5 million in savings, missing its £47.2 million target. For 2025-26, it set a recurrent savings target of £30 million, later revised to £32 million. By month seven, the Health Board had identified £32.5 million in total savings, however, there remains a £5.3 million gap in recurrent savings identified.

73 The monthly Finance Report details identified savings, but it does not show actual savings delivered. While the Finance and Performance Committee receive this information in the monthly monitoring return, it would be clearer to update the savings section of the Finance Report. Our 2024 Cost Savings Review included a recommendation to that effect. At month seven, the Health Board had delivered £13.9 million in savings.

74 The Health Board has made slow progress against our 2024 review of cost savings arrangements. Of the 14 recommendations, in October 2025, five were complete and nine in progress. **Appendix 2** shows the recommendations and current status.

Financial management arrangements

75 The Health Board has the expected financial controls and management in place, overseen by the Audit and Assurance Committee. It continues to receive assurance reports on financial controls, including counter fraud, single tender actions, procurement breaches and losses and special payments. The Health Board continues to strengthen procurement processes and reduce the number of decisions taken via Chairs Actions. These were last reported to the committee in November 2025.

76 In May 2025, Internal Audit issued a Substantial Assurance report on core financial systems. The review focused on the general ledger and accounts receivable and made two medium priority recommendations related to debt follow-up and monthly reconciliations.

77 Our cost savings review recommended strengthening accountability for savings delivery by issuing accountability letters to executive directors and clinical boards. This has not been implemented. While clinical boards are held to account on financial performance at executive performance reviews, issuing accountability letters would reinforce financial accountability.

78 The Health Board continues to have a good understanding of its key cost drivers, which is reported in the monthly finance report. At month seven the Health Board reported a 9% increase in non-pay expenditure, compared to the same time last year. Key areas driving this include secondary care and GP prescribing, primary care contracts and Continuing Healthcare.

79 The Health Board submitted its draft 2024-25 Financial Statements within the required timescales, and they were received by the Audit and Assurance Committee and the Board in June 2025. The Auditor General issued an unqualified true and fair audit opinion, however his regularity opinion was qualified because the Health Board did not meet its revenue resource requirements over the three-year period.

Monitoring financial performance

80 The Health Board has appropriate arrangements for overseeing and scrutinising financial performance, which have been strengthened in response to growing financial challenges.

81 The Finance and Performance Committee continues to receive clear updates on financial performance, risks, and challenges. The report format was improved in April 2025 following a review by the NHS Executive's Financial Planning and Delivery Unit.

82 The Board continues to receive updates via the Finance and Performance Committee Chair's report and minutes and the finance section of the IPR. As outlined in **paragraph 35**, the Health Board has updated Finance and Performance Committee membership to strengthen oversight. However, the Independent Member for Finance vacancy presents a risk.

83 Last year we recommended strengthening operational performance deep dives by triangulating performance and financial information. However, no operational deep-dives have taken place this year to allow Health Board officers to focus on addressing its current challenges.

Recommendations

84 The following table details the recommendations arising from our work.

Recommendations

R1 The Health Board should improve oversight of the strategic portfolios by:

1.1 Ensuring committees receive routine updates on strategic portfolio development and delivery relevant to their remit (**see paragraph 20**).

1.2 Structuring the Integrated Performance Report against the strategic portfolios, rather that the quadruple aims, to make it easier to track progress against Annual Plan and strategy delivery (**see paragraph 54**).

R2 Given the volume of policies overdue for review, the Audit and Assurance Committee should receive progress updates twice a year (see **paragraph 30**).

R3 The Health Board should improve its reporting format so that key issues are clearly identified to enable scrutiny and discussion to focus on key challenges. For example by considering an 'Alert, Advise, Assure' format which is used successfully in other NHS bodies (see **paragraph 37**).

R4 Given recent Board and committee changes, the Health Board should ensure its Board effectiveness report reflects on how its improvement activities have strengthened Board and committee working (see **paragraph 47**).

R5 The Health Board must develop a Performance Management Framework to support performance improvement and accountability (see **paragraph 52**).

R6 The Health Board should strengthen monitoring of quality and safety by:

6.1 Ensuring it complies with the Duty of Quality requirement to produce an annual quality report (see **paragraph 59**).

6.2 Reporting annually on how it is achieving its Duty of Candour (see **paragraph 59**).

6.3 Review arrangements for monitoring and agreeing the clinical audit plan at committee level (see **paragraph 60**).

R7 The Health Board should clarify Board and committee arrangements for reporting on its Quality Improvement and Efficiency Plan (see **paragraph 71**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period June 2025 to November 2025:

- How well the body prepares key strategies and plans.
- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers.
- Model Standing Financial Instructions.

- Relevant Welsh Government health circulars and guidance.
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Standing Orders and Standing Financial Instructions.
- Key strategies and plans, including the IMTP.
- Key risk management documents, including the Board Assurance Framework.
- Annual Report, including the Annual Governance Statement.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chief Executive
- Executive Director of Finance
- Executive Director of Nursing
- Executive Director of Allied Health Professionals, Health Sciences, and Community services development
- Director of Corporate Governance
- Head of Corporate Governance
- Corporate Archivist and Records Management Manager
- Corporate Governance Officer
- Vice Chair
- Independent Member – Capital and Estates
- Independent Member – Finance
- Independent Member – Community

- Independent Member – University

We observed Board meetings as well as meetings of the following committees:

- Finance and Performance Committee
- People and Culture Committee
- Quality Committee
- Audit and Assurance Committee
- Digital and Infrastructure Committee
- Mental Health Legislation Committee

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Health Board in implementing outstanding recommendations from previous structured assessment reports.

2024 Recommendations	
R1	To ensure ongoing scrutiny of the Annual Plan, as part of the Integrated Performance Report, the Health Board should reintroduce the quarterly high-level overview of achievements against Annual Plan milestones; and highlight how delivery of the milestones is impacting performance in priority areas (**in progress, see paragraphs 19 and 20**).
R2	In order to strengthen its administrative governance arrangements, the Health Board should ensure that:
2.1	All relevant Board and committee meeting papers are publicly available and published on its website in a timely manner. (**complete, see paragraph 24**)
2.2	Standing Financial Instructions are reviewed annually and that changes are formally documented or equally that no amendments are required. (**complete, see paragraph 27**)
2.3	Up to date Board and committee workplans are available to the public. (**in progress see paragraph 39**)

2.4	All Board and committee papers use the correct cover report template. (**complete, see paragraph 36**)
2.5	The public is signposted to the current Board Assurance Framework. (**complete, see paragraph 48**)

R3	As part of its review of arrangements for Patient Safety Walkabouts, the Health Board should consider how to ensure learning and resulting actions from walkabouts is reported to the Board. (**complete, see paragraph 41**)

R4	As part of its continuous approach to reviewing Board and committee effectiveness, the Health Board should capture and report improvement activities and consider whether they are achieving the intended benefit. (**superseded by R4 2025**)

R5	The Health Board should ensure that arrangements for scrutinising strategic and corporate risks are clarified and consistent across all committees. (**in progress, see paragraphs 48 and 49**)

R6	The Health Board should refresh the Risk Management Strategy to ensure it includes new arrangements for recording and escalating operational risks. (**in progress, see paragraph 50**)

R7 The operational performance deep dives received by the Finance and Performance Committee should be triangulated with financial performance information. (**no progress, see paragraph 83**)

2023 Recommendations

R1 Whilst the Health Board's new well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. The Health Board, therefore, should consider incorporating additional priorities that encompass all aspects of sustainable development, particularly those that relate to the environment (**in progress, see paragraph 12**).

R4 The Health Board should review the effectiveness of its new committee structure. The review should pay particular attention to whether (**superseded by R4 2025**):

- the committee structure supports sufficient oversight of the refreshed strategic objectives
- committee terms of reference and workplans adequately cover all aspects of Board business;
- there is merit in instigating a regular meeting for committee chairs;
- there is an appropriate training and development for new committee chairs and new committee members; and
- Officers and Members have the capacity and resources to support more frequent committee meetings.

R6 The Health Board has improved its Integrated Performance Report (IPR). Whilst we recognise it is a new and evolving report, we have found potential to enhance it by:

a) strengthening its links with the Annual Plan Delivery Report to ensure the relationship between some of the delivery milestones and key performance indicators is clearer (**superseded by R1.2 2025**)

b) having a more consistent focus on actions being taken to tackle underperformance in both the IPR and its cover report; (**superseded by R3 2025**)

c) being clearer about whether the metrics in section two of the IPR are on target or not (**in progress, see paragraph 54**)

d) providing benchmarking data (where available) to show how the Health Board compares to other health bodies (**in progress, see paragraph 54**).

R7 The Health Board should develop a report for the Audit and Assurance Committee pulling together common themes, issues and learning from the internal, external and regulatory compliance reports (**in progress, see paragraph 64**).

2022 Recommendations

R1	The Health Board plans to refresh its ten-year strategy by 2023. It should seek to use this opportunity to review and reshape its wider processes, structures, resources, and arrangements, to ensure they are fully aligned to the organisation's refreshed strategic objectives and associated risks, with a particular focus on its:
b)	Performance Management Framework (**superseded by R5 2025**)
c)	Committee structures, terms of reference, and workplans (**complete, see paragraph 10**)
d)	Long-term financial plan (**in progress, see paragraph 70**)

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Health Board in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

Recommendation	
R1	The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them. (**in progress**)

R2 The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by:

2.1 Extending its use of data and intelligence across a wider range of services. (**in progress**)

2.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. (**in progress**)

2.3 Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas. (**in progress**)

R3 The Health Board should assure itself that its investment in the Value in Health Team is supporting service improvement, delivering improved outcomes, and achieving cost reductions. (**complete**)

R4 The Health Board should strengthen both its guidance and governance around the Quality Impact Assessment processes for savings. This will ensure a consistent and clearly documented and understood approach for considering quality, patient safety, and intra Health Board impacts of savings decisions. (**complete**)

R5 The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total. (**complete**)

R6	The Health Board should strengthen accountability for savings delivery by issuing accountability letters to Executive Directors and Clinical Boards which provide clarity around roles, responsibilities, and financial targets. (**in progress**)
R7	The Health Board should strengthen its arrangements for communicating its cost savings plans to staff. (**in progress**)
R8	The Health Board should set challenging but realistic targets for its individual savings schemes and manage risks to under-delivery more effectively. (**in progress**)
R9	The Health Board needs to identify sufficient capacity and capability to deliver longer-term service objectives (including in the fields of innovation and improvement) to effectively deliver its operational savings plans and longer-term service transformation. (**in progress**)
R10	The Health Board should strengthen its financial reporting on savings by including actual savings delivery progress for each scheme during the year to provide stronger assurances that savings plans are delivering as intended. Financial reports should also include a short technical appendix to provide clearer information and explanation of technical accounting transactions or issues that may result in revised end of year savings forecasts and performance. (**complete**)

R11 The Health Board should ensure earlier savings planning preparation for the 2025-26 financial year and develop a rolling programme of reserve savings schemes to help mitigate any risks to savings under-delivery or where savings requirements change in-year. (**in progress**)

R12 The Health Board should identify the key lessons from its approach to identifying and delivering savings at pace during 2023-24 and apply the learning to its future approach. (**complete**)

3 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework sets out the risks linked to the organisation's strategic objectives, and the controls and assurances in place to manage those risks.
Clinical Services Plan	A Clinical Services Plan is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.

Term	Description
Integrated Medium Term Plan	An Integrated Medium Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Losses	Losses include things like theft, fraud, overpayments, or damage to property.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation sets out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.

Term	Description
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
Special Payments	Special payments are one-off payments made in unusual situations – like compensation or goodwill gestures – that fall outside of the organisation's normal business activity.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response form

Archwilio Cymru
Audit Wales

Audited body	Cardiff and Vale University Health Board
Audit name	2025 Structured Assessment
Response received	26 January 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should improve oversight of the strategic portfolios by: 1.1 Ensuring committees receive routine updates on strategic portfolio development and delivery relevant to their remit (see report paragraph 20).	With a new Executive Director of Strategic Planning joining in the Spring the resource and focus should be available to ensure this can be achieved. It is certainly fully supported by the Chair and Director of Corporate Governance. The IPR will be evolving this year in line with the discussions being led by Welsh Government on the use of SPC and power BI.	December 2026 December 2026	Executive Director of Strategic Planning Director of Operational Planning and Performance

Saunders,Nathan
28/01/2026 16:29:25

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	1.2 Structuring the Integrated Performance Report (IPR) against the strategic portfolios, rather that the quadruple aims, to make it easier to track progress against Annual Plan and strategy delivery (see report paragraph 54).	Whether this lands the IPR as being directly aligned with the strategic portfolios will become evident as the work evolves.		
R2	Given the volume of policies overdue for review, the Audit and Assurance Committee should receive progress updates twice a year (see report paragraph 30).	A policy update will be shared bi-annually in May and November Audit Committee.	November 2026	Director of Corporate Governance
R3	The Health Board should improve its reporting format so that key issues are clearly identified to enable scrutiny and discussion to focus on key challenges. For example, by considering an 'Alert, Advise,	Welsh Government recommendations for the development of performance reporting includes an approach very aligned to 'Alert, Advise, Assure' although not exactly the same. It uses Variation and Assurance. We will review this recommendation over	November 2026	Director of Corporate Governance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	Assure' format which is used successfully in other NHS bodies (see report paragraph 37).	the next 6 months and conclude on the best method and means to be implemented.		
R4	Given recent Board and committee changes, the Health Board should ensure its annual Board effectiveness report reflects on how its improvement activities have strengthened Board and committee working (see report paragraph 47).	Board improvement and self-assessment is now a standing item at all Board Development sessions. The Chair's report will be used not just to report on this activity but set out how the activities have strengthened working.	December 2026	Director of Corporate Governance
R5	The Health Board must develop a Performance Management Framework to support performance improvement and accountability (see report paragraph 52).	This will be a key output that will need to coincide with the organisational development work and form part of the operating model.	December 2026	Executive Director of Finance and Executive Director of Strategic Planning

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6	The Health Board should strengthen monitoring of quality and safety by: 6.1 Ensuring it complies with the Duty of Quality requirement to produce an annual quality report (see report paragraph 59). 6.2 Reporting annually on how it is achieving its Duty of Candour (see report paragraph 59). 6.3 Review arrangements for monitoring and agreeing the clinical audit plan at committee level (see report paragraph 60).	Duty of Quality report 24-25 will appear at Quality Committee in March and future reports will appear earlier in the year. These actions will be addressed as part of a current review of the Quality Committee.	March/December 2026 December 2026	Executive Director of Nursing Executive Director of Nursing and Assistant Directors of Patient Safety and Patient Experience

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R7	The Health Board should clarify Board and committee arrangements for reporting on its Quality Improvement and Efficiency Plan (QIEP) (see report paragraph 71).	The QIEP will continue to evolve. Savings, productivity and efficiency are reported within the Finance and performance reports through the Finance and Performance Committee.	October 2026	Deputy Director of Finance and Deputy Director of Operations

Archwilio Cymru
Audit Wales

Cardiff and Vale University Health Board – Annual Audit Summary 2025

Date issued: January 2026

Contents

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Foreword

Adrian Crompton

Auditor General for Wales

I am pleased to share my Annual Audit Summary for Cardiff and Vale University Health Board. It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work and reviewed planned care services, urgent and emergency care services and eye care services. As set out in my audit plan, these reviews have been carried out in line with the International Organisation of Supreme Audit Institutions (INTOSAI) standards.

At the time of publishing this summary, the whole Health Board was escalated to Level 4 under the Welsh Government's escalation and intervention arrangements.

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit and Assurance Committee throughout the year. The performance audit reports are available on the Audit Wales website and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the Audit Wales website.

I would like to extend my gratitude to the Health Board's staff for their help and cooperation throughout my audit.

Your audit at a glance

I received the draft accounts in line with the statutory deadline of 2 May 2025. The quality of the draft accounts and working papers was good.

In advance of the statutory deadline of 30 June 2025 I issued an unqualified true and fair opinion, and a qualified regularity opinion.

There were no uncorrected misstatements in the accounts. There were no other significant issues to report.

My performance audit work found that the Health Board has sound corporate governance arrangements and is taking steps to strengthen systems of assurance. However, while financial oversight, control and management processes are in place, the Health Board's financial position is a significant concern.

Despite efforts to reduce elective waiting lists, sustainable improvements have not been achieved. Service changes are supporting improvement in managing urgent and emergency care demand, but the service remains under significant pressure, requiring ongoing action to use existing capacity effectively.

My audit team made several recommendations to the Health Board which focus on strengthening service planning, monitoring and oversight, risk management, financial and digital controls, support for transformation and enhancing operational efficiency to improve patient care and experience and service sustainability.

There is still some work outstanding from my Audit Plan dated April 2025. My team expects to complete this work by March 2026.

Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give and true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

The draft accounts were presented for audit on 2 May 2025. This was in line with the deadline of 2 May 2025 set by the Welsh Government. The quality of the draft accounts presented for audit was generally good.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Audit Committee and Board on 25 June 2025.

True and fair

A number of changes were made to the draft accounts arising from my audit work.

There were no uncorrected misstatements.

There were no other significant issues to report.

My work did not identify any material weaknesses in internal controls but I made 4 recommendations which related to IT controls. Progress against these recommendations will be monitored during next year's audit.

I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Health Board is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it.

Further, where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

The Health Board did not achieve financial balance for the three-year period ending 31 March 2025, which I deem to be outside its powers to spend, so I have issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2024-25 accounts. The LHB did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £4,122 million by £70.820 million.

Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance and the failure to have an approved three-year plan in place.

Whole of Government Accounts

I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2025 and the return was prepared in accordance with the Treasury's instructions.

Performance audit findings

Structured assessment

My team looked at how well the Health Board is governed and whether it makes the best use of its resources.

I found that the Health Board has demonstrated an inclusive approach for developing its Annual Plan, supporting delivery of its long-term strategy. It is accelerating work on its Clinical Services Plan and improving Board-level reporting on Annual Plan delivery. However, strategic portfolios require well-defined delivery roadmaps and stronger committee oversight.

The Board and committees continue to work well, remaining committed to public transparency and hearing from patients and staff. While the Board has continued to experience significant turn-over this has been well managed. However, the absence of an Independent Member for finance presents a risk. Opportunities remain to enhance Board and committee papers and effectiveness reviews.

The Health Board continues to strengthen and digitalise its systems of assurance. However, there is still a need to improve risk and performance management, and to strengthen aspects of quality and safety monitoring and recommendation tracking.

The financial position remains a significant concern, with a forecast year-end deficit of £56.2 million against a £9.1 million control total. Although the Health Board has identified all planned savings, there is still a shortfall against its recurrent savings target. As in previous years, it was unable to submit a financially balanced three-year Integrated Medium-Term Plan to Welsh Government. Work to develop a long-term financial model remains at an early stage.

I made ten recommendations focused on:

- improving committee oversight of strategic portfolios;
- more frequent reporting on policies overdue for review;
- enhancing Board and committee papers by focusing on key issues and impact;

- enhancing Board and committee effectiveness reviews;
- developing a Performance Management Framework;
- strengthening aspects of quality and safety monitoring; and
- clarifying Quality Improvement and Efficiency Plan reporting at Board level.

The Health Board has fully implemented six outstanding recommendations since our last structured assessment report, nine are still in progress, five have been superseded by new recommendations and there has been no progress against one.

Managing planned care

My team looked at the progress the Health Board is making in tackling its planned care challenges and reducing its waiting list backlog.

I found that while the Health Board made reasonably good progress initially, it did not meet the Welsh Government's waiting list reduction targets. Despite work to drive operational service improvements, the Health Board's approach did not achieve the desired positive impact on planned care performance until recently. Consequently, the waiting list substantially grew during 2024.

There is a risk that improvements are unsustainable and reliant on additional short-term funding. The Health Board, therefore, urgently needs a financially and clinically sustainable plan to meet growing service needs and secure improvements in planned care performance.

I made nine recommendations focused on:

- developing a planned care improvement plan;
- applying demand and capacity modelling consistently across specialties;
- building programme capacity and capability to support service transformation;
- developing a planned care risk register;
- providing committee level assurance on planned care programme delivery;
- strengthening Board reporting on the impact of additional planned care funding;
- focusing on actions to improve service efficiency and productivity;

- implementing the Promote, Prevent and Prepare for Planned Care policy; and
- strengthening monitoring and reporting processes for clinical risks associated with long waits.

Managing urgent and emergency demand

My team looked at how well the Health Board is managing demand for urgent and emergency care to reduce unnecessary pressure on the system.

I found that service changes are supporting improvements to the management of urgent and emergency care demand, underpinned by robust plans and strong corporate oversight. However, urgent and emergency care services within the Health Board are still under significant pressure and ongoing action is needed to ensure existing capacity is used to best effect. Further action is also needed to ensure both patients and staff have a better understanding of the range of services available and how to access them. Securing further improvements would be aided by involving Welsh Ambulance Services NHS Trust (WAST) staff in the Six Goals Delivery Board and by capturing staff and patient feedback on how well services are working.

I made eight recommendations focused on:

- clarifying funding arrangements for Six Goals Programme initiatives;
- strengthening signposting arrangements to ensure patients access the right services;
- developing clear, accessible referral pathways;
- improving the WAST directory of services;
- improving patient feedback surveys, response rates and addressing findings in future plans;
- strengthening joined up planning and service change by including WAST as a member of the Six Goals Delivery Board;
- strengthening committee reporting on attendance and conveyance rates to the minor injuries; and
- evaluating project benefits of Six Goals Programme initiatives.

Review of Eye Care Services

My team looked at whether the Health Board has effective arrangements to improve eye care services. My team reviewed local and regional arrangements.

I found that the regional eye-care strategy sets a positive direction, but progress has been slow. Governance arrangements are in place to oversee regional delivery, but decision-making on business cases can be slow and cumbersome, involving multiple groups across the three health boards. It is worth noting that regional working has shifted away from its original ambition of developing specialist services more broadly, focusing instead on creating short-term service capacity for cataract procedures. While the regional cataract approach aims to reduce long waits, thus far it has not significantly impacted the overall number of patients awaiting treatment.

The Health Board is reducing its longest ophthalmology waits, but too many eye care patients are still waiting a long time. While performance against the 'eye-care measure' is above average, it falls well short of the national target, increasing the risk of avoidable harm.

The Health Board has taken positive steps to strengthen leadership and address cultural challenges within the ophthalmology service. It has also set up clear processes for identifying, reporting, and learning from harm caused by delays in the ophthalmology waiting list. However, it needs to strengthen long-term planning of eye care services, secure further productivity and efficiency gains and improve Board level oversight.

I made five recommendations, three for the Regional Ophthalmology Programme Board and two for the Health Board. These focussed on:

- regional partners speeding up decision-making processes for agreeing business cases;
- regional partners developing a resource plan to better understand the operational and clinical commitment needed for each partner organisation;
- regional partners agreeing realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy;

- the Health Board urgently developing an eye care plan, seeking to address current and future challenges; and
- the Health Board providing routine updates on the ophthalmology service action plan to the Finance and Performance Committee.

Performance audit work still underway

At the time of reporting, the following reviews from the 2025 Audit Plan were still underway at the Health Board:

- review of digital transformation
- review of cancer services
- review of estates management
- clinical coding follow-up review: progress update

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use three lines of assurance to show how we achieve this. We have set up an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Information on our upcoming work and forward work programme for performance audit.

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Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Report Title:	Procurement Compliance Report					Agenda Item no.	2.5
Meeting:	Audit Committee		Public	X		Meeting Date:	February 2026
			Private				
Status *(please tick one only):*	Assurance	X	Approval			Information	
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Deputy Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report

Background and current situation:

It is widely recognised and understood that the UHB requires that the purchase of all its goods and services is undertaken in accordance with current legislation and the application of good procurement practice, taking into consideration the minimum thresholds for quotes and competitive tendering arrangements. The process is governed by a legal framework to ensure transparency, fairness, and value for money for public funds.

A significant proportion of the HB's non-pay expenditure is influenced by Procurement Services however; there will be instances where the application of a competitive process cannot be followed (e.g. patient safety/legislation) and these instances are permitted by the HB and outlined in its Standing Orders (SO's)/Standing Financial Instructions (SFI's). There are pre-determined circumstances where expenditure may appear to be non-compliant, however, due to reasons such as patient safety and legislation, e.g. UKAS Registration, Rent/Rates, these are exempt from a procurement process due to the nature of the requirement. In recognition of these situations, Single Quotation Actions (SQA) or Single Tender Actions (STA) are requested in accordance with the Procedure for the Approval of STA.

However, it should be noted that the number of STA/SQA's has significantly reduced since the inception of enhanced training, competition via the multi-quote system, and Procurement Services working with the Clinical Boards to award longer term contracts.

It should also be noted that for exemptions, Audit Teams highlight what appear to be non-compliant issues. However, despite Procurement being unable to influence this expenditure, these are referenced as non-compliant in their Audit Reports.

Executive Director Opinion and Key Issues to bring to the attention of the Committee:

ASSESSMENT AND ASSURANCE

<u>Non-Compliant Activity (17)</u>

This is activity where departments have engaged suppliers without Procurement involvement and Therefore, they have incurred a direct breach of SFI's.

Description Title	Value at Risk Excl VAT	Length at Risk/ Breach	Clinical Board	Reason	Action/Status
CEF Staff Awards 2025 Final Payment for Venue and Technology	£14,706.33	One-off Requirement	Capital Planning Estates and Facilities	No discussion with procurement prior to raising requisition.	Advised CEF that for any future requirements the end users liaise with Procurement Services in a timely manner to allow contract to be put into place via a compliant process.
GPN Programme 2025/26	£51,002.00	9 months	PCIC	Funded Placement across 3 GP Practices via HEIW - not taken into account HB SFI and governance. Advised	Met with HEIW to understand their process and advised for future requirements would require

				for next year's training would involve us with EOI and procurement to be involved from the beginning.	Procurement Services to be involved from the beginning to advise.
UPSW Investigation – Payment of Invoice	£15,683.00	Retrospective POI	Medicine	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Emailed end user explaining over 5k orders need to be discussed with Procurement Services prior to raising
ZytoLight CEN 17/SPEC ERBB2 Dual Color Probe - 0,2ml/20tests x 10	£12,425.00	Retrospective POI	AWMGS	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Emailed end user explaining over 5k orders need to be discussed with Procurement Services prior to raising
Repair of Balloon Pump	£7,953.75	Retrospective	Specialist	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Unforeseeable circumstance, repair not covered on maintenance contract one off, no action
Payment of Invoice – IPCRESS Project	£22,192.00	Retrospective	Specialist	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Emailed end user explaining over 5k orders need to be discussed with Procurement Services prior to raising
Spectra Optia Correct Connect IDL Set Box6 (12020)	£5,360.88	Retrospective	Specialist	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Procurement Services to arrange to add to contract
Artisse Implant Device Ref ISF-075-050	£9,500.00	Retrospective	Clinical Diagnostics &Therapies	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Procurement Services to review ongoing requirements with Clinical Board and add this to the Neuro Framework that is currently being scoped/tendered.
PO2Pay – Panel Shipment and initiation Fee	£18,100.00	Retrospective	AWMGS	No initial Procurement involvement until requisition was received.	Procurement Services to review ongoing requirements with Clinical Board.
Synlab – Outsourcing of Tests	£344,277.71	April 2025 to March 2026	AWMGS	Synlab are not on any compliant frameworks, and this has been identified through No PO No Pay IOH as uncompliant spend	Procurement Services reviewing all spend and HB requirements to secure a compliant formal contract from April 2026
The Institute of Narrative Therapy, Inhouse L1 Training	£5,170.00	November 2025	Mental Health	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Explained to end user the process of orders over £5,000 and that they are to contact Procurement Services for any future orders that will be over the value of £5,000.
Therma solutions Hurrichem Consumables –	£7,500.00	Retrospective	Surgery Services	Retrospective payment of invoice costs to be recovered from HCRW	Explained to end user the process of orders over £5,000 and that they are to contact Procurement

Payment of Invoice					Services for any future orders prior to calling off from provider that will be over the value of £5,000.
Custom Bone Plate	£8,687.09	Retrospective	Specialist	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Procurement Services reviewing with dept to ensure a contract is formalised to call this type of purchase off going forward
Locum Placement ALAC	£11,528.00	Retrospective	Clinical Diagnostics &Therapies	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Procurement Services in discussions with ALAC to advise on compliance steps required for future activity.
Patient Specific Procedure Reagents	£9,501.00	Retrospective	Clinical Diagnostics &Therapies	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Review usage and look to get contract in place with items available via catalogue
200 Carbs and Cals App Codes and X18 World Food Books	£5,322.85	One off Requirement	Children & Women	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	Explained to requestor the process and to include Procurement Services for future orders.
Payment of Invoice Wound SAAS Annual Aug 25 to July 26	£90,404.00	Retrospective	PCIC	No procurement involvement - despite trying to discuss as reported to audit last year	Escalated concerns after numerous attempts to get compliance and engagement from end user, not informed Procurement Services.

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (2)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Survey of Building Energy Management System	£15,000.00	2025	One-off requirement	Capital Planning Estates and Facilities	The contract is overspent, with the new contract currently being approved by Welsh Government. However, this £15,000 is for retrospective spend in relation to the current agreement.	The new contract is currently in the process of being approved by Welsh Government and is expected to start on the 1st of February 2026. This expenditure will be the last in relation to the current agreement.
Additional funding for social prescribing	£7,000.00	31.03.26	November 2025 - Mar 2026	PCIC	Contract expired at end of agreed funding period. Service advised additional funding required to continue in progress.	Working with directorate on renewal from April 1st, 2026

Other Non-Compliant Activity (5)

This section details activities which were out of the Department/Health Board's control as a result of any of the following.

- Emergency activity
- Unforeseen/Unplanned circumstances

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Forticare Premium Support	£42,571.18	One-off Requirement	AWMGS	Emergency Activity	Contract was not recorded on Procurement Services or AWMGS contracts work plan so were not aware of requirement until it was too late to put in compliant process. Supplier confirmed that support would be terminated if PO is not received. This has been added to the procurement workplan to ensure a compliant route to market and governance is completed on the renewal.
UHL Nuclear Medicine Detector Repair	£8,813.84	One-off Requirement	Clinical Diagnostics &Therapies	Emergency Activity	Accidental damage to UHL apollo detector, not covered by maintenance contract, 2 spare parts required
Custom Glenoid Materialise Hire	£15,363.55	One-off Requirement	Surgery Services	Emergency Activity	Custom patient specific item, unable to use shelf kit - retrospective requisition. Department advised to engage with Procurement Services.
FedEx Import Charges	£11,327.31	One-off Requirement	AWMGS	Emergency Activity	Goods being held by customs until import charges are paid – not known at point of Procurement Services
Replacement X Ray Tube in Children's Radiology Samsung / GC80CW / 2678/ S087M3AF500001B	£10,050.00	One-off Requirement	Clinical Diagnostics &Therapies	Emergency Activity	Emergency Repair to mitigate disruption to services

Exemptions (3) (Permitted within SFI's)

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status
IMC St Davids – insurance renewal 2025-26	£32,117.49	One-off Requirement	Capital Planning Estates and Facilities	Exemption	This expenditure is exempt under PFI
UKAS – Inspection Quotes	£17,033.50	One-off Requirement	Clinical Diagnostics &Therapies	Exemption	Review of all depts requiring UKAS accreditation. Look at large CB or potentially HB wide rolling contract as requirement will always be there and with sole supplier rationale
IQAS & QPIDS Annual Subscription	£5,060.00	12 months	Specialist	Exemptions	Regulatory requirement. Review all licences required from supplier and consolidate in one contract via transparency notice for multi-years as true sole source

It should be noted that Procurement Services has booked training sessions with areas of high non-compliance on Standing Financial Instructions (SFI's) and Procurement Legislation and Regulations to proactively reduce the number of breaches by Clinical Boards. In anticipation of the repeated end-of-year budget position, Clinical Boards will be reminded of their obligation to engage with Procurement Services in advance of their intention to raise requisitions for goods and/or appoint a provider for services, so that the appropriate route to market is adhered to for compliance.

Report on Single Tender/Quotations Actions

Retrospective – (Nil Return)

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (2) requests during the period from the 1st November 2025 to 31st December 2025.

It should also be noted that, because of the exemptions highlighted by Audit for Rent/Rates, regulatory requirements and Legislation, the majority will relate to historical arrangements that will have already been presented to the HB for approval, and the associated costs will have been included as part of the Business Case process for budgeting purposes. In addition, for the more recent instances, these again will already have been presented for HB approval.

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
Executives	Problem Resolution Ltd	Group Mediation and individual mediation for several senior clinicians within Cardiology	£28,100.00	Urgent Operational Issue
Medicine	St David's Recruitment	Supply of Administrative Staff for the Mobile Endoscopy Unit based at Royal Glamorgan Hospital.	£59,886.65	Urgent Operational Issue

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

	2023/24 (FY)		2024/25 (FY)		2025/26(YTD)	
Clinical Board	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption
AWMGS	1	0	14	0	10	1
Children and Women	3	0	11	0	5	3
Capital Planning, Estates and Facilities	2	3	17	7	19	15
Clinical, Diagnostics and Therapies	11	4	27	4	27	9
Executives	21	9	35	20	8	1
Medicine	1	0	3	0	2	0
Mental Health	2	1	10	0	1	4
PCIC	2	0	11	0	7	5
Specialist	10	1	11	2	10	2
Surgery and Dental	10	0	8	1	4	0

TOTALS	**63**	**18**	**147**	**34**	**96**	**39**

STA/SQA's by Department

	2023/24 (FY)		2024/25 (FY)		2025/26(YTD)	
Clinical Board	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached
AWMGS	0	0	6	1	1	0
Children and Women	4	0	2	0	2	0
Capital Planning, Estates and Facilities	2	0	7	0	2	0
Clinical, Diagnostics and Therapies inc. Weqas	23	0	34	0	6	0
Executives	13	2	22	2	2	0
Medicine	0	0	3	0	1	0
Mental Health	1	0	3	0	0	0
PCIC	3	0	4	0	0	0
Specialist Services	3	0	5	2	0	0
Surgery Services and Dental	5	1	9	0	0	0
Grand Total	**54**	**3**	**95**	**5**	**14**	**0**

Summary of the Key Issues progress

Work continues to address the key drivers of non-compliance across Clinical Boards. Procurement has observed ongoing fluctuations in non-compliant spend, largely linked to exemptions, emergency repairs, and retrospective approvals. Awareness of Standing Financial Instructions (SFI's) remains varied across directorates, with early engagement still inconsistent and contract lifecycle management requiring further strengthening.

Training is underway, with plans to introduce measurable KPIs to assess its effectiveness and identify areas needing additional support. Governance processes remain predominantly reactive due to limited early involvement, but several improvements are being progressed. Procurement Services continues to enhance digital monitoring through QlikSense and AdviseInc, with longer-term plans to combine these into an integrated governance dashboard.

Key improvement actions are in development, including rapid-response frameworks for emergency requirements, mandated early-engagement protocols, strengthened contract monitoring, and the full documentation of exemptions to ensure audit-ready justification. While these measures will take time to embed, they are expected to drive sustained improvements in compliance and future audit outcomes.

There is likely non-compliant activity that we will not be aware of, as they could only now emerge, as departments need to clear down outstanding payments - we can highlight these in the next report.

Recommendation:

The Committee are requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
Putting People First		Providing Outstanding Quality	x
Delivering in the Right Places	x	Acting for the Future	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
As outlined above
Safety:
As outlined above
Financial:
As outlined above
Workforce:
As outlined above
Legal:
As outlined above
Reputational:
As outlined above
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
28/01/2026 16:29:25

STA/ SQA	SQA/STA Number	Contract Folder Number	Procurement Officer	Date Received	Clinical Board Requestor	Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Annual Value of Contract excl VAT	Retrospective?	Retrospective Value of Contract excl VAT	Start Date of Contract	End Date of Contract	Extension Option	Type	Category of STA/SQA for Audit Paper	Reason Detail for STA	Long Term Solution
STA	CAV STA (2025/26) 54	CR1415	ID	24/09/2025	David Fluck	Executives	Problem Resolution Ltd	Group Mediation and individual mediation for a number of senior clinicans	£28,100.00	£33,720.00	No	N/A	29/09/2025	31/03/2026	N/A	Urgent Operational Requirement	Compliance / Regulatory Requirements	the Health Board must commission a company to undertake group and individual mediation with a group of 12 consultants. Failure to instigate timely mediation will result in additional locum costs, a further breakdown in relationships and potential employment tribunal action for the South East Wales Vascular Network	N/A as it's a one off requirement
STA	(2025/26) 39	IOS42	BE	22/08/2025	Vicci Page	Medicine	St. David's Recruitment	Supply of Administrative Staff for the Mobile Endoscopy Unit based at Royal Glamorgan Hospital.	£59,866.65	£59,866.65	No	N/A	04/09/2025	31/03/2026	N/A	Urgent Operational Requirement	Compliance / Regulatory Requirements	Cwm Taf Morgannwg University Health Board have established a Mobile Endoscopy Unit for the provision of diagnostic services. The facility has capacity for CAVUHB to refer its patients to the Unit for diagnostic procedures to be undertaken, to reduce patient waiting times. Whilst there is no requirement to source any consumables and equipment, it is necessary to employ temporary staff to support the administration processes as CAV does not have the staff to transfer on a temporary basis due to existing pressures. Various recruitment agencies have been approached and only St. David's have staff that can be available on an immediate basis and who are trained to use the systems	Temporary solution to maximise opportunity of reducing waiting lists

February 2026
Supplementary information for the Director of Finance - Report on Single Tender/Quotations Actions

Category reason for SQA/STA's

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Unforeseen/unplanned circumstances
12. Exemptions

Retrospective – (Nil Return)

The report outlines all retrospective SQA/STA (0) requests during the period the 1st November 2025 to 31st December 2025.

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract Excl VAT	Type	Reason Detail for STA	Category

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (2) requests during the period the 1st November 2025 to 31st December 2025.

The volume processed was as a consequence of the following: -

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Unforeseen/unplanned circumstances
12. Exemptions

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract Excl VAT	Type	Reason Detail for STA	Category
Executives	Problem Resolution Ltd	Group Mediation and individual mediation for several senior clinicians	£28,100.00	Urgent Operational Issue	The Health Board must commission a company to undertake group and individual mediation with a group of 12 consultants. Failure to instigate timely mediation will result in additional locum costs, a further breakdown in relationships and potential employment tribunal action for the South East Wales Vascular Network	11
Medicine	St David's Recruitment	Supply of Administrative Staff for the Mobile Endoscopy Unit based at Royal Glamorgan Hospital	£59,886.65	Urgent Operational Issue	Cwm Taf Morgannwg University Health Board have established a Mobile Endoscopy Unit for the provision of diagnostic services. The facility has capacity for CAVUHB to refer its patients to the Unit for diagnostic procedures to be undertaken, to reduce patient waiting times. Whilst there is no requirement to source any consumables and equipment, it is necessary to employ temporary staff to support the administration processes as CAV does not have the staff to transfer on a temporary basis due to existing pressures. Various recruitment agencies have been approached and only St. David's have staff that can be available on an immediate basis and who are trained to use the systems	8

Reference Number: UHB 023 **Version Number:** 2.1	**Date of Next Review: 31.01.2029**

Risk Management Policy

Policy Statement

This risk management policy establishes:

- Systems for effective risk management that is integral to the day-to-day operation of the organisation.
- Clear lines of accountability to ensure the management of risk.
- Arrangements to identify the risks that may threaten the achievement of the objectives of the UHB. This will include arrangements for reporting incidents and raising concerns.
- Appropriate action in response to the identification of unacceptable risks.
- Clearly defined structures for providing assurance through the organisational hierarchy up to the Board that risks are being managed.
- Alignment of risk management activity to the corporate aims, objectives and organisational priorities of the UHB, to protect and enhance the reputation and standing of the organisation.
- The embedding of a risk culture where risk analysis forms part of organisational strategic planning, business planning, Quality Management and performance management.

Putting the above arrangements in place will enable the organisation to:

- Become proactive rather than reactive.
- Identify and treat risk throughout the organisation.
- Improve identification of opportunities and threats.
- Comply with relevant legal and regulatory requirements.
- Improve financial reporting and the effective allocation of resources.
- Establish a reliable basis for decision making and planning.
- Improve incident management and prevention.
- Improve organisational learning.
- Improve organisational resilience.

Policy Committment

Cardiff and Vale University Health Board (UHB) is committed to robust, proactive risk management as a core part of good corporate and clinical governance. We aim to identify risks, incidents and mistakes quickly, respond constructively, learn lessons, and prioritise resources to continually improve safety and quality.

We will achieve this by:

- Fostering a culture of openness to reduce and, where possible, eliminate risks.
- Aligning all risk management activities with UHB aims, objectives and priorities to protect and strengthen the organisation's reputation.
- Embedding risk analysis into strategic planning, business planning and project appraisal.
- Implementing routine risk assessment to identify, control and monitor risks that could affect service quality or safety.
- Ensuring clear communication of risk-related issues across the organisation and with stakeholders.
- Maintaining an effective incident reporting system to reduce incidents, claims and complaints.
- Demonstrating to patients, staff and the public that we manage risk to deliver safe, high-quality care at the right time and in the right place.
- Encouraging responsible innovation by supporting calculated, well-managed risk-taking that benefits the organisation.
- Providing a strong foundation for integrated risk management and internal control as part of good governance.
- Monitoring the effectiveness of risk management using performance indicators.

Supporting Policies and Procedures

- UHB 043 Raising Concerns (Policy) to be read alongside the UHB Speaking Up Safely Guidance
- UHB 138 Incident, Hazard and Near Miss Reporting Policy
- UHB 467 Risk Assessment Procedure - Health and Safety
- UHB 470 – BAF AND ASSURANCE (Under review)

Other supporting documents are:

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- See Risk SharePoint page for further guides and supporting documents

Scope

This Policy is applicable across the whole of the UHB. It should also be referred to when ensuring effective risk management arrangements are in place when working with contractors, partner organisations e.g. Local Authorities and other stakeholders.

Policy Approved by	Audit Committee
Accountable Executive	Director of Corporate Governance
Author	Corporate Archivist and Records Management Manager

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1.1	25.01.2011	28.01.2011	*New policy to replace and update documents from predecessor organisations*
1.2	09.07.2023	26.11.2023	Change to Statement of Intent, revised management arrangements, changes to executive responsibilities, references to the Annual Governance Statement, minor amendments to Section 12 and amendment of document title regarding incident reporting.
1.3	01.07.2025	01.07.2025	Full review of Policy conducted, transfer to new template, slight updates throughout
2.1	TBC	TBC	Full policy rewrite to reflect the change to using AMAT as a single system for monitoring risk.

Table of contents

Appendices

1. Introduction

The University Health Board (UHB) has moved to a single digital risk management system on AMaT (Audit Management and Audit Tracking). **It is mandatory for all Clinical Boards and Directorates to record their risks on AMaT, ensuring one accurate and accessible risk register for the whole organisation**. This centralised approach strengthens transparency, supports consistent risk management practices, and enables clearer oversight from ward level through to the Board.

Historically, AMAT has been used across the UHB for Clinical, Quality and external Audit management and was considered a tool already well embedded. The risk module can link to these previous services. It also allows related risks to be linked, helping teams understand how a risk in one area may affect others.

For example, if there is a risk with medication, distinct areas or groups, such as the Medicine Safety Group are able to log a risk and communicate it through their stakeholder membership, who in turn will have the awareness to raise the risk and score it reflectively within their own Clinical Boards. This enables each Clinical Board or Service to review and create a risk entry of their own, assessing the level of impact within their respective service. These risks can be cross referenced for increased awareness and transparency allowing for different teams to view the varying impact and proposed controls across the UHB.

Support for using AMAT is available from Corporate Governance via Corporate.Meetingcav@wales.nhs.uk and a range of resources can be found on the Risk SharePoint page. Training is also available through pre-recorded sessions and ad hoc workshops, as described further in Appendix B.

The Institute of Risk Management defines risk management as

'*the process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure*'

As well as supporting better decision making and improved efficiency, risk management can also provide greater assurance to stakeholders that concerns

are being managed and mitigated as effectively as possible. Risk management adds value to the organisation and risk management activities must achieve the best possible outcomes and reduce the uncertainty of these outcomes.

Risk management must be embedded into UHB culture, so people need to be alive to it and talking about risk right across the organisation.

2. Key Points

2.1 Definitions

There are some common definitions that staff need to be aware of when it comes to understanding risk which are set out below:

Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored in a way that will enable organisations to minimise losses and maximise opportunities
Hazard	Something that may cause harm, damage or loss, e.g. chemicals, manual handling
Risk	The chance of suffering harm caused by a hazard, loss or damage or the possibility that the UHB will not achieve an objective
Risk Assessment	The overall process of identifying risk and evaluating whether acceptable or not taking into account best practice and the appetite of the organisation.
Risk Appetite	The amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time

A full list of definitions can be found at **Appendix E.**

2.2 Organisational Risks

This policy covers the management of risks that impact the organisation. There are many project risks that impact the delivery of more local work, these do not form part of the organisational risk register and should be managed locally outside of this policy.

2.3 Incidents and Risk

Staff must be aware of the difference between what an incident and risk is.

Risk

- A risk is something that might happen in the future and could affect the organisation's ability to achieve its objectives.

- Risk management is proactive, aiming to identify, assess, and mitigate potential threats before they materialise.
- It is characterised by uncertainty and is expressed in terms of likelihood (probability of occurrence) and consequence (impact if it occurs).

Example: *There is a risk that staff shortages could compromise patient safety.*

Incident

- An incident is an event that has already happened or is certain to happen, often resulting in harm or near miss.
- Incident management is reactive, focusing on reporting, investigating, and learning from events to prevent recurrence.

Example: *A patient fall on a ward is an incident that needs to be reported and reviewed.*

For incident management staff must refer to the UHB 138 Incident, Hazard, and Near Miss Policy and support can be provided by the Patient Safety Team.

2.4 Cause v Effect

When recording a risk, staff must be clear whether they are describing the cause of the risk ***or*** the effect it could have.

- Cause based risks focus on what might trigger the problem. The risk owner should be the person responsible for that part of the service.
- Effect based risks focus on the potential impact on patients, services or staff. The risk owner should be the person accountable for managing that impact.

Being clear about the cause or effect helps ensure each risk is owned by the person best placed to control or reduce it.

An example of this would be recording Lifts on a Risk Register

- **Cause-Based** - There is a risk that lift failure or unavailability, caused by mechanical faults or ongoing maintenance could occur, as the ageing lift infrastructure is prone to intermittent malfunction. This risk is owned by Capital, Estates & Facilities because it arises from asset condition and maintenance requirements.
- **Effect-Based -** If lift downtime occurs, patient movement between floors may be delayed, causing potential disruption to clinical pathways,

delayed transfers, and reduced service efficiency. This risk is owned by the affected service area, as they are responsible for managing the operational impact.

3. Risk Architecture

Risk architecture is the organisational arrangements for risk management detailing the responsibilities, system, roles and lines of communication for reporting on risk management.

3.1 Responsibilities

All Staff – risk is everyone's responsibility. All members of staff are accountable for maintaining risk awareness, identifying and reporting risks as appropriate to their line manager

Managers- must take an active lead to ensure that risk management is embedded into the way their service/team/ward operates & their staff understand and implement this Policy, ensuring that staff are provided with the education and training to enable them to do so

Directors/ Clinical Board Directors- are responsible for implementation of the Board Assurance Framework (BAF) and this Risk Management Policy. They must ensure that there is an active risk culture within their area and risks are escalated as appropriate

Executive Directors - are responsible for ensuring their directorates are implementing the Board Assurance Framework (BAF) and this Risk Management Policy and will ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the health board's strategic objectives

Director of Corporate Governance - works with senior leaders to maintain the Risk Management Policy and Board Assurance Framework, strengthen shared understanding of organisational risks, and promote clear risk awareness. They oversee risk management across the UHB, ensure the BAF is delivered effectively, monitor actions and reporting, and lead the development of the UHB's overall risk management approach

Their team work with Executives and Managers to co-ordinate integrate, oversee and support the risk management agenda, ensuring that risk management principles are embedded across the UHB. The team will also

liaise with Audit Teams regarding Risk Management. The team will download all risks that score 20-25 for inclusion in the Corporate Risk Register for submission to Board from the centralised register (AMaT) and support with co-ordinating Risk Training.

Chief Executive - is the Accountable Officer of the UHB and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls and governance.

They have overall accountability and responsibility for ensuring that the health board maintains an up-to-date Risk Management Policy and a Board Assurance Framework that is endorsed by the Board.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed

3.2 Risk Register System

The digital risk management system on AMAT (Audit Management and Audit Tracking) provides a live, accurate and accessible risk register for the whole organisation. The system is set up across four levels of the UHB:

AMAT	Local definition	Example
Division	Clinical Board	Medicine CB
Business Unit	Directorate/Department	Integrated Medicine
Speciality	Workstream/Service	Stroke
Ward or Site	Ward or Site	C5 South

Essentially, teams need to set up their risk hierarchy and service structure in the right way that works for them, ensuring that all their different teams, departments and services are assigned to enable risks to be logged in AMaT at the appropriate level of where or who the risk impacts

Contact the Digital Risk Lead, if you need assistance accessing the Risk system or configuration changes to enable your service area . A document containing

the full list of services in AMAT can be found here, this document is updated regularly. This is not fixed and teams must ensure that their departments are adequately configured to ensure effective risk management in their areas.

3.3 Roles

Staff have the ability to view all risks across the organisation provided they have been added to the AMAT system.

Risks are managed on AMAT by the appropriate person from the department depending on the severity of the risk. Generally, risk must be managed at the lowest level possible, proportionate to the level of exposure.

The appropriate access needs to be given to staff who will record risks in AMAT. Those staff will need to be added into the system as **Risk Stakeholders** enabling them to add, approve and edit a risk within a service.

Once a risk is submitted on AMAT, it appears as a draft and must be approved by an **Approver**. This is to ensure the risk entry is acceptable, accurately recorded and proportionate. The Digital Risk lead will work with departments to ensure appropriate approvers are in place.

The ability to edit and manage risks is done in AMAT by the assignment of different roles for users. If you're a ward manager and need to approve, monitor and escalate risks into your Ward meetings, you will need different access to a Nurse who has recorded the risk into the AMAT system. This means teams need to look at their risk hierarchy, in AMAT terms this translates to different levels of Stakeholders. Some staff will only need to work on risks for their area, others will want to review and approve risks right across all departments that sit under them. A Clinical Board Director for example will want to be a Divisional Stakeholder so they have visibility of everything across their Clinical Board. A General Manager will be a Business Unit Stakeholder having access to everything in the department they manage.

*Stakeholders for different Service levels	Example of Service levels	Example of Service levels
Division Stakeholders can view, edit and manage all risks across the Division, Business Unit and all Specialities	Division = Medicine CB Business Unit = Integrate Medicine Speciality = Stroke **Full table of the current Service Areas can be found** here	Division = Corporate Business Unit = People & Culture Speciality = Equity & Inclusion
Business Unit Stakeholders can view, edit and manage all risks across the Business Unit and Specialities - unable to edit Divisional risks		
Speciality Stakeholders can view, edit and manage all risks across a set speciality only - unable to edit Divisional and Business Unit risks including risks from assigned to other specialities		
Approver - ability to review draft risks and approve or reject the risk appearing on the proposed register.		

In the example above Clinical Board representatives who require oversight and the ability to create risks at any level within the clinical board, will be assigned

Divisional Stakeholder access. This level enables full visibility and management capability across the entire Division, including all Business Units and Specialities.

Colleagues who need access across an entire Directorate (Business Unit) will be assigned **Business Unit Stakeholder** access. This allows them to enter and manage risks for the whole Business Unit, including all Specialities within it. When raising a risk, they may set it at the Business Unit level - when the risk affects all linked services or at an individual Speciality level if the risk impacts a single service.

Colleagues working directly within a service will be assigned **Speciality Stakeholder** access, enabling them to enter and manage risks only for that Speciality. They will not be able to edit risks at Business Unit or Divisional level or risks belonging to other specialities.

This can vary from Clinical Board to Clinical Board. An example of a structure is:

Division	Clinical Board Director / Quality & Clinical Governance
Business Unit	General Managers / Directorate Leads
Speciality	Service leads / All users

A Stakeholder and User type guide is available which provides more detail around this.

3.4 Risk Owner

Once a risk has been identified, analysed and evaluated a Risk Owner must be appointed. Risk owners should be the individuals best placed through their authority and influence to take responsibility for mitigation of the risk. The identified risk owner is responsible for:

- Ensuring that the risk is managed appropriately, controls are in place to mitigate the risk and actions are set out on AMAT to address gaps in control measures.
- Reviewing the risk register at appropriate intervals to ensure the descriptor, controls and risk score accurately reflect the level of risk and that progress is being made at sufficient pace to reduce the risk score to the target risk level.
- Communicating with specialist areas to discuss the joint working needed to manage the risk effectively before they are assigned as an Action Owner.

- Assigning action owners within AMAT to ensure they are aware of their responsibilities for delivering actions.
- Reporting on the overall status of the risk, escalating where appropriate in line with the Risk Reporting and Escalation table detailed in section 4.6 of this policy.

3.5 Action Owner

Action owners have responsibility for the activities needed to address gaps in control measures and the assurance of the effectiveness of existing controls. Action owners are required to report progress to Risk Owners in a timeframe and manner identified by the Risk Owner. Action owners will normally be identified from within the same Clinical Board or Corporate Directorate as the Risk Owner but specialists from other areas of the organisation, such as HR or H&S may also be required to perform as specialist action owners.

3.6 Assurance

The Three Lines of Defence Model

The UHB operates a 'Three Lines' model, with the diagram below outlining the principles for the roles, responsibilities and accountabilities for risk management.

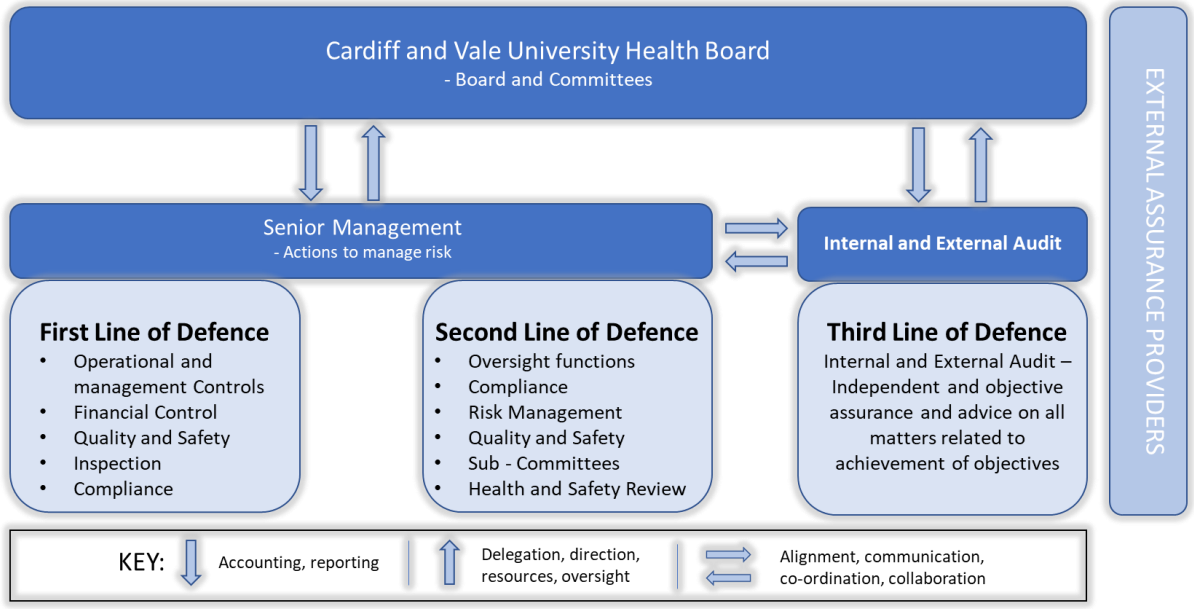

Figure 1 – Three lines of defence Model

In the 'Three Lines of Defence' model, management control is the first line of defence in risk management. The various risk control and compliance oversight functions established by management are the second line of defence, and independent assurance is the third. Each of these three "lines" plays a distinct role within the UHB's wider governance framework. All three lines need to work interdependently to be effective.

The Board has responsibility and accountability for setting the organisation's objectives, defining strategies to achieve those objectives, and establishing governance structures and processes to best manage the risks in accomplishing those objectives.

4. Risk Life Cycle

The cycle of managing risks involves a series of defined steps through which risks are identified, recorded and monitored to ensure they remain within acceptable levels. This systematic approach ensures that risks are managed consistently across the organisation and that issues are escalated or deescalated appropriately through established governance mechanisms. This cycle is set out below in more detail.

4.1 Assessment

If you think you may have an organisational risk, the first step is to undertake a risk assessment.

A suitable and sufficient risk assessment can be undertaken by following the 5 steps detailed below. It is reasonable to review the diagram below and have a discussion with your Line Manager.

Once it is confirmed that a new risk has been identified, the details must be entered onto AMAT the digital risk management platform. All risks regardless of score must be recorded.

Supporting risk documentation must be uploaded to the risk record in AMAT to support the risk and evidence controls and assurances. This is to ensure a contemporaneous record is held and this can be effectively audited. Documentation can include risk assessment forms, evidence of controls which can include but is not limited to policies/procedures/protocols/SOPs etc.

The Health & Safety Executive require all Health & Safety risks to undergo detailed scrutiny, these risks need to be identified through the completion of risk assessments which can be uploaded to the organisational risk register. Health & Safety Risk Assessments must be retained whilst they remain current and for 3 years after they are closed and 40 years for asbestos related documentation as per the Risk Assessment Procedure - Health & Safety.

Undertaking an initial assessment of the activities or objectives to be achieved will help managers to identify those areas that require a more in-depth assessment. Risk assessments should not be undertaken in isolation as a multi-disciplinary approach is encouraged.

4.2 Methods of Managing

Effective risk management aims to anticipate and where possible, avoid risks rather than deal with their consequences. However, this approach is not practicable for all risks. The intention must always be to reduce the risk by all reasonably practicable means. Once it has been reduced to the lowest level possible then it must be carefully managed.

It is necessary to manage risks in the most efficient and effective manner. AMAT is configured to manage Risks in line with the 4 T's format set out below.

Terminate Risk	taking the decision not to take a risk
Treat Risk	by reducing the probability of the risk occurring or by reducing the impact
Tolerate Risk	an informed decision to accept the consequences and the likelihood of a particular risk, for example where the probability or consequence is so low that the cost of managing it would be prohibitive, compared to the benefit or it is not within the remit of the organisation to prevent the risk e.g. emergency situations. For such situations Contingency Plans will need to be developed, e.g. Business Continuity Plans. This will allow the UHB to contain the negative effect of unlikely events that might occur.
Transfer Risk	Risk managed/mitigated by another organisation, for example insurance or contracting out (although still need to have regard of legal responsibilities which cannot be transferred

4.3 Factors

There are a number of factors to determine the nature and the level of impact each risk might present to the organisation. In order to help people score risks consistently a Risk Factors Score Guide found at Appendix D has been developed to provide clear, consistent definitions for staff to rate the severity of their risk. This ensures that risks are assessed systematically, understood across the organisation, and escalated appropriately.

4.4 Scoring

The UHB has a 3-part risk scoring process which is set out below and mirrored on the digital risk management system.

Initial Risk Rating (inherent)	The risk score (Impact x likelihood) assessed before the application of risk treatments/controls
Current Risk Rating	The risk score (Impact x likelihood) assessed at a specific period of time. The current risk rating will usually be lower than the initial rating but higher than the target risk rating
Target Risk Score	The estimated achievable risk score when all risk treatments and mitigations are in place and operating at maximum effectiveness.

The score of a particular current risk rating will determine at what level decisions on acceptability of the risk are to be made and where it needs to be reported.

The UHB operates a 1-25 risk scoring system which is set out below and mirrored on the digital risk management system.

Risk Level	Risk Score	Action
Extreme Risk	20 - 25	Immediately report the risk to the relevant Executive Director or Clinical Board Director.
High Risk	8 - 16	Report to Clinical Board (or for Corporate Directorates to the Executive Director).
Moderate Risk	4 - 6	Report to Heads of Service with proposed treatment/action plans, for particular monitoring.
Low Risk	1 - 3	Report to local manager for local action to reduce risk

4.5 Review & Update

All risks must have a review date, which must be entered manually by the user into AMaT. Once added, the review date appears in AMaT reports and data downloads, allowing teams to track when reviews are due. The risk register can also be filtered by these dates, helping users easily identify upcoming or overdue reviews and maintain timely oversight. In addition, approaching and overdue review dates will automatically notify the stakeholders that reviews are required.

The timescale for this will be influenced by the risk rating and the ability of the organisation to introduce control measures. As control measures are introduced the assessment must be reviewed as a series of incremental actions will gradually reduce the risk rating.

4.6 Escalation

Staff are expected to use their professional judgement and apply common sense when escalating risks. Not every issue will require escalation, but where a risk cannot be managed safely or effectively at a local level—or where the potential impact is significant—it must be escalated to the appropriate level of the organisation in a timely and proportionate way.

The **Risk Reporting Hierarchy** (shown in the diagram below) provides a clear route for proportional escalation from Directorate Risk Registers to Clinical Board and Corporate Risk Registers, and ultimately to the Board Assurance Framework. Risks will move through this structure only as far as necessary to ensure they are owned, understood, and effectively managed.

The table below outlines the UHB's graded approach to risk escalation and oversight.

Score	Level	Action	Review	Oversight
1 - 3	Low Risk	Quick, easy measures implemented immediately, and further action planned for when resources permit	Risk Review meetings – at least 6 monthly	Local service
4 - 10	Moderate Risk	Quick, easy measures implemented immediately, and further action planned for when resources permit	Ward Department Risk Review meetings – at least quarterly.	Local Service Directorate
12 – 16	High Risk	Actions implemented as soon as possible but no later than six months	Directorate Meeting Monthly Clinical Board/QSE Quarterly	Local Service Directorate Clinical Board
20 - 25	Extreme Risk	Requires urgent action. The UHB Board is made aware, and it implements immediate corrective action	SLT – responsible for moderating Executive Clinical Board Reviews Committees Board	Local Service Directorate Clinical Board Executive/Board

Appendix A Lines of Defence in Risk Management – Roles and Responsibilities

Board and Committees (Top Governance)

Set Strategic Objectives & Risk Appetite; Protect organisational reputation; Provide leadership on risk; ensure consistent approach;

Review BAF (strategic) & Corporate Risk Register (≥20) each meeting; Endorse risk-related disclosures (e.g., Annual Governance Statement)

FIRST LINE OF DEFENCE
OPERATIONAL OWNERSHIP

Clinical Boards & Corporate Directorates

Own and manage operational risks; Review, update & escalate extreme risks; Present escalated risks to SLT; Managers apply UHB risk processes

Central Corporate Functions

Provide specialist risk support:

Corporate Governance; Patient Safety & Learning; Health & Safety; Capital Estates & Facilities; Finance; Workforce & OD; Occupational Health

Local Counter Fraud Services

Deliver annual work plan on fraud/corruption; Investigate and report to Audit & Assurance Committee; Record risks in relevant registers and escalate as required

Health & Safety Team

Provide H&S risk advice and specialist assessments; Align H&S and organisational risk management

SECOND LINE OF DEFENCE
OVERSIGHT & CHALLENGE

Audit & Assurance Committee

Assess effectiveness of Risk Management & BAF; Review assurance processes and disclosures ; Oversee sound systems of governance and risk ; Review Corporate Risk Register and advise on strengthening

Management Executive & SLT

Promote open reporting culture; Forum for key risk discussion & escalation; Agree ratings and action plans across HB; Provide assurance for Annual Governance Statement

Other Board Committees

Scrutinise specific domains; Provide assurance to Board on their BAF elements

Quality Committee

Monitor and manage clinical risks; Assure quality & safety of patient centred care

THIRD LINE OF DEFENCE
INDEPENDENT ASSURANCE

Internal Audit

Independent assurance on internal controls

Review effectiveness of risk management arrangements

Risk based audit programme; report to Audit & Assurance Committee

Appendix B - Training

Details on risk training options is set out on the Risk Sharepoint Page

AMAT Training & Guidance

Video tutorial on how to add a new risk to AMAT
AMAT Risk Module Guidance

Non-Specific Training and Support- It is recognised that, in addition to the above there may emerge a need for non-specific risk management training and support. Where this is applicable please contact the Digital Risk Lead or the Corporate Governance team to discuss the support and training required

Appendix C – Risk Factors Score Guide

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days. service well below reasonable public expectation. Prolonged negative social media, reported in national media. long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days. service well below reasonable public expectation. Extensive, prolonged social media, MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets,10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0,1–0,25% of budget Claim less than £10,000.	Loss of 0,25–0,5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0,5–1,0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss of service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

Appendix D – Risk Scoring

Likelihood score	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring

Impact x Likelihood Risk Grading	1 Rare	Unlikely	Possible	Likely	Almost Certain
Negligible	1	2	3	4	5
Minor	2	4	6	8	10
Moderate	3	6	9	12	15
Major	4	8	12	16	20
Catastrophic	5	10	15	20	25

Appendix E – Definitions

Annual Governance Statement	A document which provides a high level account of the structures in place to support governance and review of their effectiveness. It will be produced at the same time as the annual accounts.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved
Assurance Committee	A board level committee with overarching responsibility for ensuring appropriate assurance is gained on the management of all principal risks. This function will be performed by the Audit Committee
Barriers	Actions, Measures or Processes that prevent mitigating controls being established.
Board Assurance Framework (BAF)	The key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board will use in discharging its overall responsibility for internal control.
Corporate Risk Register	Candidate risks comprise of all risks with a current risk rating of 20 or above, or those risks with a lower score which in the opinion of the risk owner that require greater visibility within the organisation to manage due to authority/resource, or their complexity or the potential for a health board wide impact.
Controls	Any process, policy, device, practice or other conditions/actions which modify risk. A risk treatment becomes a control once the effectiveness of the treatment has been confirmed through assurance processes
Current Risk Rating	The risk score (Impact x likelihood) assessed at a specific period of time. The current risk rating will usually be lower than the initial rating but higher than the target risk rating
Escalation	The act of advancing a risk to a higher management level for resolution, action or attention
Event	The occurrence or change of a particular set of circumstances. An event can have one or more occurrences and can have several causes and several consequences
Exposure	The consequences, as a combination of impact and likelihood, which may be experienced by the organisation if a specific risk is realised.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively

Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
Hazard	Something that may cause harm, damage or loss, e.g. chemicals, manual handling
Horizon Scanning	Systematic activity designed to identify, as early as possible, indicators of changes in risk.
Impact	The outcome of an event that has affected objectives. Can be certain or uncertain and can have positive, negative, direct or indirect effects on objectives. Can be expressed qualitatively or quantitatively
Initial Risk Rating (inherent)	The risk score (Impact x likelihood) assessed before the application of risk treatments/controls
Likelihood	The chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively, or quantitatively, and described using general terms or mathematically
Operational risks	These are key risks that affect individual Clinical Boards and Corporate Directorates. They are managed within the Clinical Boards and Corporate Directorates and where necessary included in the Corporate Risk Register and potentially BAF
Residual Risk	The exposure arising from a specific risk after action has been taken to manage it and making the assumption that the action is effective
Risk	The effect of uncertainty on objectives. An effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities or threats. The chance of suffering harm caused by a hazard, loss or damage or the possibility that the UHB will not achieve an objective
Risk Acceptance	An informed decision to accept (tolerate) the consequences and the likelihood of a particular risk, for example where the probability or consequence is so low that the cost of managing it would be prohibitive compared to the benefit or it is not within the remit of the organisation to prevent the risk e.g. emergency situations.
Risk Appetite	The amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time

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Risk Assessment	The overall process of risk identification, risk analysis and risk evaluation. It must be conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of stakeholders. It must use the best available information, supplemented by further enquiry as necessary
Risk Avoidance	Taking the decision not to take a risk
Risk Categories	Identify and help classify risks based on potential consequences for example risks impacting on Quality or Infrastructure
Risk Management	A systematic process by which potential risks are identified, assessed, managed and monitored in a way that will enable organisations to minimise losses and maximise opportunities
Risk Reduction	By reducing the probability of the risk occurring or reducing the impact
Risk Register	A register of all risk across the UHB identified within a team, department, speciality, board/directorate or the UHB as a whole.
Risk Terminate	Take a decision to remove the risk by stopping the related activity entirely
Risk Tolerate	A decision is taken to accept the risk if impact is low or manageable.
Risk Transfer	Shift risk to third party, e.g. insurance or contract
Risk Treat & Risk Treatment	Implement controls to reduce likelihood or impact of risk. Any process, policy, device, practice or other conditions/actions with the potential to modify risk in a desired manner. Risk treatments become controls once their effectiveness in modifying the risk is assured.
Strategic risks	These are significant risks that have the potential to impact upon the delivery of Strategic Objectives and therefore need to be raised and monitored by the Executive Team and the Board
Target Risk Score	The estimated achievable risk score when all risk treatments and mitigations are in place and operating at maximum effectiveness.

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Report Title:	Counter Fraud Progress Report				Agenda Item no.	4.1	
Meeting:	Audit & Assurance Committee		Public	x	Meeting Date:	03/02/2026	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Catherine Phillips						
Report Author (Title):	Henry Bales						

Main Report
Background and current situation:

The Counter Fraud Progress report seeks to provide assurance to members of the Audit Committee that the Counter Fraud work being undertaken is satisfactory, robust and compliant with NHS Counter Fraud Authority requirements.

The report provides information around key areas of work including fraud awareness and learning, proactive investigation and reactive work, and promotional activity.

Executive Director Opinion and Key Issues to bring to the attention of the Committee:

Progress made against the Annual Counter Fraud Plan
Promotional /Educational Activity
Summary of Investigations
Prevention activity
National Fraud Initiative
Significant Salary Overpayments

Recommendation:

The Committee are requested to **note** the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

Putting People First		Providing Outstanding Quality	x
Delivering in the Right Places	x	Acting for the Future	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/~~No~~

Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.

Safety: ~~Yes~~/No

Financial: Yes/~~No~~

All fraud occurring in the organization has a financial loss to the organization.

Workforce: Yes/~~No~~

Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes/No
Reputational: Yes/~~No~~
Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Catherine Phillips	

NHS WALES

Counter Fraud Progress Report

04/11/2025 – 16/01/2026

Public

HENRY BALES
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of the Health Board.

This report relates to activity for the reporting period 04/11/2025 – 06/01/2026.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2025-2026, and the NHS CFA functional standards. The below activity has taken place -

i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.

ii. Continued maintenance of Counter Fraud digital platform – **Members of the Audit and Assurance Committee are encouraged to visit the site at the link/QR code here**

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

E-Learning Awareness Sessions – The ESR E-Learning package remains available for staff to access and is promoted through the Counter Fraud SharePoint page and our other publications. Proposal to request mandating of this e-learning is being drafted in response to the Failure to Prevent Fraud Legislation.

Awareness Sessions – Counter Fraud continue to participate in corporate induction events for new starters. During this period three of these sessions has taken place with 'mini' talks being given to all in attendance (circa 140 members of staff).

International Fraud Awareness Week – through IFAW digital communications were publicised throughout the week. The various articles can be viewed from the links below:

International Fraud Awareness Week - November 16-22

International Fraud Awareness Week 2025 - Working Elsewhere Whilst Sick

International Fraud Awareness Week 2025 - Timesheet/Expenses Fraud

International Fraud Awareness Week 2025 - Overpayments

Fraudbusters!

Stay Safe This Christmas Fraud Article – The festive period can be one of heightened risk of fraud both personally and as an organisation. With this in mind a special Christmas fraud awareness article was published with information on how to stay safe and some common types of fraud at this time of year. The article can be viewed here: Stay Safe This Christmas: Fraud Awareness Tips for NHS Staff.

Prevention

Fraud Prevention Notice – (3)

Three Fraud Prevention Notices produced by Counter Fraud Authority relating to Payment Terminal Fraud, Virtual Credit Cards and Payment Diversion Fraud. They have been reviewed no new risks or actions identified.

Referrals

During this reporting period there have been a total of 30 referrals made to the team. 5 of these referrals have been promoted to investigations (detailed in next section). 4 referrals remain in initial assessment stage. The remaining referrals have all been closed.

Investigations

During this period there have been 5 investigations commenced by the counter fraud team. There have been 5 investigations that have been closed on the system. This means that there are currently 10 investigations open at the time of this report. Summaries of the opened, closed and currently open cases are shown below.

Investigations opened in the period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/25/03248	Recruitment Concerns	04/11/2025		
INV/25/03382	Primary Care Contractor - Dispensing Fraud	13/11/2025	20/11/2025	Intelligence shared, no further action
INV/25/03640	Accessing records	01/12/2025	03/12/2025	No fraud found
INV/25/03947	Potential access to data	23/12/2025		
INV/25/03953	Theft of Cash	23/12/2025		

Investigations Closed in this period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/24/03059	Theft of Medication	CARRIED OVER - 29/11/2024	05/01/2026	Disciplinary sanction
INV/25/01599	Working whilst sick	05/06/2025	23/12/2025	No fraud found
INV/25/03382	Primary Care Contractor - Dispensing Fraud	13/11/2025	20/11/2025	Intelligence shared, no further action
INV/25/03640	Accessing records	01/12/2025	03/12/2025	No fraud found
INV/25/03168	Working whilst sick	28/10/2025	01/12/2025	No fraud found

Investigations that remain open

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/01634	Salary Sacrifice Vehicle	CARRIED OVER - 03/08/2023		
INV/23/02002	Theft of Controlled Drugs	CARRIED OVER - 15/09/2023		
INV/24/00462	Working elsewhere whilst sick	CARRIED OVER - 21/02/2024		
INV/25/00286	Overtaking leave	CARRIED OVER - 03/02/2025		
INV/25/00720	Theft of Cash and Medication	CARRIED OVER - 11/03/2025		
INV/25/02172	Working elsewhere whilst sick	14/07/2025		
INV/25/02716	False prescriptions	15/09/2025		
INV/25/03248	Recruitment Concerns	04/11/2025		
INV/25/03947	Potential access to data	23/12/2025		
INV/25/03953	Theft of Cash	23/12/2025		

3. Significant Salary Overpayments

There have been five significant salary overpayments reported for this period. All of these have been reviewed by the counter fraud team, none have required escalation to formal criminal investigations.

NB. The All-Wales Salary Overpayments Policy requires that the Counter Fraud team review all 'significant' salary overpayments prior the employee being informed of the issue.

The Counter Fraud team have a five-day window to carry out an initial assessment of the surrounding circumstances and decide whether the matter will be formally investigated as a financial crime.

"Significant" overpayments are defined in the policy as overpayments that have a total value of over £5,000 and have been ongoing for a period of over 3 months.

A digital dashboard has been developed and implemented to assist with the monitoring of salary overpayments, their causes and the departments where they occur. This dashboard is accessible to the Finance and Counter Fraud teams.