

Public Audit & Assurance Committee Meeting

Tue 18 November 2025, 09:00 - 11:00

Microsoft Teams

Agenda

09:00 - 09:10
10 min

1. Preliminaries

David Edwards


1.1. Welcome, Introductions & Apologies for Absence

1.2. Declarations of Interest

1.3. Minutes of the Committee meeting held: 02.09.2025

 1.3 Public Audit Committee Minutes 02.09.2025.pdf (9 pages)

1.4. Actions following meeting held: 02.09.2025

 1.4 Action Log - Public Audit & Assurance.pdf (2 pages)

1.5. Any Other Urgent Business


09:10 - 10:40
90 min

2. Items for Review & Assurance

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

Ian Virgil / Internal Audit

 2.1 A&A Progress Report November 25 cover.pdf (2 pages)

 2.1a A&A Progress Report November 25.pdf (13 pages)

 2.1b CVU-2526-16 DoLS Final Internal Audit Report.pdf (11 pages)

2.2. Audit Wales Update (20 MINUTES)

Wales Audit

 2.2 CVUHB Audit Committee Update (November 2025).pdf (12 pages)

 2.2a CVUHB National Fraud Initiative Briefing note.pdf (9 pages)

2.3. Deep Dive on Procurement and Non-Pay Spend (20 MINUTES)


Catherine Phillips / Claire Salisbury

 2.3 Deep Dive Procurement Services part2.pdf (6 pages)

2.4. Procurement Compliance Report (5 MINUTES)

Catherine Phillips

 2.4 Procurement Report - November 2025 Final.pdf (8 pages)

 2.4a Procurement - CVU Audit Committee November 2025 v2.pdf (8 pages)

2.5. Procurement Compliance Report – Chairs Action Review (5 MINUTES)

Chilcott, Rachael
12/11/2025 16:08:12

Catherine Phillips

📄 2.5 Procurement Chair's Action.pdf (3 pages)

2.6. Triannual Audit Tracker update (10 MINUTES)

Matt Phillips

📄 2.6.1 - Audit Tracker Update Report - Nov 2025.pdf (6 pages)

📄 2.6.2 - Appendix 1 - IA closed actions since May 2025.pdf (13 pages)

📄 2.6.3 - Appendix 2 - IA unable to complete since May 2025 - Nov 2025.pdf (2 pages)

📄 2.6.4 - Appendix 3 - AW extended action dates Nov 2025.pdf (3 pages)

📄 2.6.5 - Appendix 4 - Audit Wales outstanding actions Nov 2025.pdf (15 pages)

📄 2.6.6 - Regulatory Info for November 2025 Audit Committee.pdf (3 pages)

10:40 - 10:40 3. Items for Approval/Ratification

0 min

NO ITEMS

10:40 - 10:40 4. Items for Noting & Information

0 min

4.1. Counter Fraud Progress Update

Henry Bales

📄 4.1 COUNTER FRAUD PROGRESS _ PUBLIC _ COVER SHEET P3 (1).pdf (2 pages)

📄 4.1a COUNTER FRAUD PROGRESS REPORT - CAVUHB PUBLIC P3 (1).pdf (8 pages)

10:40 - 10:40 5. Agenda for Private Audit and Assurance Committee

0 min

- i. *Counter Fraud Progress Update (Confidential – ongoing investigations)*
- ii. *People and Culture Assurance Report*

10:40 - 10:40 6. Any Other Business

0 min

10:40 - 10:40 7. Review & Final Closure

0 min

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

7.2. Date and Time of the next Committee meeting:

Tuesday 3 February 2026 via MS Teams.

7.3. 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]

Chilcott, Rachel
12/11/2025 16:38:12

**Minutes of the Public Audit & Assurance Committee Meeting
 Held On 2 September 2025 at 9:00am
 Via MS Teams**

View the full meeting here:

<https://www.youtube.com/watch?v=KbgocwvtjeU&list=PLLVdfcKNzMAA7B9IVZC6mznqn8msCNnOV&index=10>



Please note that each item has been linked below so that it will start playing from that point. If you are unable to view sections, please copy and paste the link into your preferred internet browser.

Chair:		
Rhian Thomas	RT	Independent Member for Capital and Estates and Committee Chair (CC)
Present:		
David Edwards	DE	Independent Member for ICT
Ceri Phillips	CP	Vice Chair of the Health Board
Mike Jones	MJ	Independent Member – Trade Union
In Attendance:		
Henry Bales	HB	Lead Local Counter Fraud Specialist
Claire Beynon	CB	Executive Director of Public Health
Andrew Doughton	AD	Performance Audit Manager Audit Wales
Rachel Freitag	RF	Audit Manager – Audit Wales
Lucy Jugessur	LJ	Deputy Head of Internal Audit
Amanda Legge	AL	All Wales Post Payment Verification Manager
Martyn Lewis	ML	Auditor – Internal Audit
Robert Mahoney	RM	Deputy Director of Finance
Lianne Morse	LM	Deputy Director of People & Culture
Urisha Perez	UP	Audit Lead - Audit Wales
Matt Phillips	MP	Director of Corporate Governance
Anna Schwappach	AS	Public Health Consultant
Frankie Thomas	FT	Head of Corporate Governance
John Union	JU	Independent Member for Finance
Rachna Upadhya	RU	Independent Member

Ian Virgil	IV	Head of Internal Audit
James Webb	JW	Head of Information Governance and Cyber Security
Catherine Wood	CW	Managing Director Planned Care
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People and Culture
Catherine Phillips	CP	Executive Director of Finance

Item No	Agenda Item	Action
A&A 25/09/1.1	Welcome & Introduction The Committee Chair (CC) welcomed everyone to the meeting.	
A&A 25/09/1.2	Apologies for Absence Apologies for absence were received. The Committee resolved that: a) Apologies were noted.	
A&A 25/09/1.3	Declarations of Interest The Committee resolved that: a) No Declarations of Interest were noted.	
A&A 25/09/1.4	Minutes of the Committee meeting held 20.05.2025 & the Special Meeting held 25.06.2025 (click to view) The Minutes of the Meeting Held on the 20.05.2025 & the Special Meeting held 25.06.2025 were received. One typo was identified on page 4 where “Train” should say “Trade”. The Committee resolved that: a) The draft minutes of the meetings held on 20.05.2025 & the Special Meeting held 25.06.2025 were deemed to be a true and accurate record of the meeting pending the one minor amendment.	
A&A 25/09/1.5	Actions following meeting held: 20.05.2025 (click to view) The Actions were received. The Committee resolved that: a) The Actions were noted.	
A&A 25/09/2.1	Internal Audit Progress Report: (click to view) The Internal Audit Progress Report was received. The Head of Internal Audit (HIA) provided an update on the audit progress report, highlighting that nine reports were finalised in time for the committee meeting, with two receiving limited assurance. An overview of the 25/26 internal audit plan progress was received, noting that whilst most audits were on track, the Quality and Safety Governance audit was delayed due	

to its complexity and scheduling challenges but was expected to be completed for the November 2025 meeting.

The Committee was advised that early-year performance on management response times to audits was strong, with all Key Performance Indicators (KPIs) met so far which was a significant improvement from the previous year.

The Chair expressed their thanks to everybody who had helped to achieve the improved response times and emphasised the importance of maintaining timely management responses and closely monitoring any follow-ups that still resulted in limited assurance after 12 months.

The Director of Corporate Governance (DCG) supported the Chairs comments and noted improvements in risk management and audit response processes.

The HIA noted that one change to the audit plan was highlighted within the report around the addition of a Quality and Safety Governance audit (requested by the Chair and Chief Executive) and the removal of a Clinical Board governance audit to accommodate that.

Limited Assurance Audit: Alcohol Standards Follow-Up: The HIA reported that out of seven agreed actions, three had been completed while four, including high-priority items, remained outstanding, resulting in continued limited assurance.

The Executive Director of Public Health (EDPH) explained that the audit was based on NICE guidelines, which were advisory rather than mandatory, and described dependencies on external partners and tools, such as the awaited alcohol brief intervention API from Public Health Wales.

She added that detailed steps had been taken, including establishing quarterly alcohol prevention meetings and aligning with Cardiff and Vale Drug and Alcohol Services (CAVDAS), with contractual mechanisms for monitoring.

The HIA confirmed that a second follow-up audit was scheduled in the 25/26 plan, with timing to be agreed with the EDPH to ensure improved assurance would be reported to the Committee.

Limited Assurance Audit: Cybersecurity Governance: The Auditor – Internal Audit (AIA) reported on the limited assurance audit on cybersecurity, identifying key issues in risk management, communication gaps between Digital and Clinical boards, and the need for stronger governance and accountability, with actions and proposals for improvement outlined within the report.

The Head of Information Governance and Cyber Security (HIGCS) outlined management's response to the audit, including immediate fixes for administrative issues and a proposal to the Strategic Leadership Team (SLT) to improve governance and communication between Digital and Clinical boards, aiming for shared risk management.

The Independent Member – ICT (IMICT) stressed the need for the Senior Information Risk Owner (SIRO), David Thomas, to have authority to compel Clinical Boards to implement required protections, advocating for a more fundamental change rather than improved communication alone.

The DCG described ongoing work to centralise risk registers using the AMAT system, enabling better cross-referencing and visibility of cyber risks across the organisation.

Rachna Upadhya, Independent Member (RUIM) and others highlighted the need for education and integration of cyber risk into Clinical Governance, with plans to use existing quality and safety groups or to create new forums for ongoing oversight.

The Vice Chair of the University Health Board (UHB Vice Chair) noted the need for this audit to be received by the Quality Committee for noting and for further scrutiny on cyber security to be received to align clinical risks to digital.

The DCG added that cyber should also be picked up during the Clinical Board reviews.

The CC concluded that rather than wait for the 12 month follow up report, actions should be updated regularly at the right forum and that the 12 month follow up report should then outline all of the improvements that had taken place.

Microsoft 365 Benefits Realisation Audit: The AIA discussed the reasonable assurance audit on Microsoft 365 benefits realisation, noting high expenditure, limited team resources, and the need for structured plans and digital champions to maximise benefits.

He added that that while there was a steering group and resources for Microsoft 365 adoption, the small team size and lack of structured plans and benefit tracking limited the realisation of full value from the investment.

The IMICT confirmed the value of digital champions within departments to support adoption and training, with plans being put in place to boost that network for better outcomes.

Therapies and Health Sciences Agency Additional Hours and Overtime Audit: The Deputy Head of Internal Audit (DHIA) presented the audit on agency, additional hours, and overtime for Health Sciences staff, identifying discrepancies in staffing records and incomplete documentation, resulting in limited assurance for one objective.

The DHIA noted the difficulties in reconciling vacancies, incomplete agency request forms, and insufficient evidence of approval for shifts, leading to six medium recommendations.

Waiting List Management Audit: The DHIA summarised the reasonable assurance audit on waiting list management, noting that while processes for recording, managing, and monitoring waiting lists were generally effective, four medium-level findings were identified, and the Health Board continued to manage high waiting list volumes.

Contract Management Advisory Audit: The HIA presented the advisory audit on contract management, identifying five opportunities for improvement and explaining that ***a combined action plan would be developed with Shared Services and brought to a future committee.***

Medicine Clinical Board Acute Medicine Model Audit: The DHIA reported on the reasonable assurance audit of the acute medicine model, identifying issues that historical medical staffing records were not retained, preventing assurance on staffing levels, and action plans for addressing performance audit shortcomings were unavailable at the time of review.

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	<p>The CC thanked the DHIA for the continued focus on that audit.</p> <p><u>Integrated Annual Plan Audit:</u> The DHIA presented the reasonable assurance audit on the 2526 integrated annual plan, highlighting robust governance but noting high findings due to failure to produce a balanced financial plan and incomplete savings identification.</p> <p>It was noted that the Health Board had breached its statutory financial planning duties, with only a portion of required savings identified at the time of audit, and management committed to earlier planning for future targets.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered. b) The proposed adjustments to the 2025/26 plan were approved. 	
<p>A&A 25/09/2.2</p>	<p><u>Audit Wales Update (click to view)</u></p> <p>The Audit Wales Update was received.</p> <p>The Audit Manager – Audit Wales (AMAW) advised the Committee that the current reporting period was quiet for Health Board financial audit work as the team was currently focused on local government audits.</p> <p>She reminded the Committee that the 2024/25 accounts were certified in June 2025 and that the Charitable funds audit was scheduled for November 2025, well ahead of the Charity Commission deadline of January 2026 with the <i>Charitable funds audit plan to be presented at the next Committee meeting.</i></p> <p>The Audit Lead - Audit Wales (ALAW) advised the Committee that the Planned Care review was complete and on the agenda for discussion, with Andrew Doughton, the Performance Audit Manager Audit Wales (PAMAW) to present findings later in the meeting.</p> <p>She noted that other reviews within the report were at various stages:</p> <ul style="list-style-type: none"> • Eye care services review was at the reporting stage. • Fieldwork was underway for the structured assessment and digital transformation review; the digital self-assessment was discussed at the July Board meeting. • The project brief for the clinical coding follow-up review (local work for the year) had been issued. • Estate management deep dive and local council reviews were at the planning stage. <p>The ALAW advised the Committee that exhibit 3 in the update paper provided links to recent national reports, including a cost savings arrangements checklist for Board members.</p> <p>She noted that the checklist was intended to help Board members scrutinise and assure themselves of effective cost savings arrangements within the Health Board.</p> <p>The CC and UHB Vice Chair suggested the cost savings checklist <i>be circulated to the Corporate Governance team, Board, and Clinical Board leaders</i>, as it</p>	

	<p>contained pertinent questions and could support savings monitoring and engagement.</p> <p><i>The DCG agreed to ensure it was distributed.</i></p> <p>The ALAW concluded by advising the Board that Audit Wales was updating its report format to make reports clearer, easier to read, and more accessible. The new format would be seen in upcoming reports, and feedback was welcomed.</p> <p>The Committee resolved that:</p> <p>a) The Audit Wales Audit Updates were noted.</p>	
<p>A&A 25/09/2.4</p>	<p>Post Payment Verification End of Year report 2024/25 (click to view)</p> <p>The Post Payment Verification (PPV) End of Year report 2024/25 was received.</p> <p>The All Wales Post Payment Verification Manager (AWPPVM) provided an update on PPV activity, highlighting a significant workload in 24/25 due to a high number of General Medical Services (GMS) revisits, with only 38 out of 54 planned visits completed for the Health Board.</p> <p>She noted that the shortfall was attributed to unexpected staff absences and the complexity of revisits triggered by small sample sizes and a new payment system.</p> <p>It was noted that additional service checks were introduced, and the team had caught up on overdue work in the first quarter of 2025/26.</p> <p>The AWPPVM emphasised ongoing efforts to recover overdue work and improve reporting, including training and video guides for practice managers.</p> <p>The CC suggested that future reports should provide more context for Committee members, especially new ones, including the purpose, importance, and implications of PPV work.</p> <p>She also requested that the data be contextualised—explaining whether results were above or below average, and what the findings meant for the organisation.</p> <p><i>The AWPPVM agreed to revise the reporting format and share drafts for feedback before the next meeting.</i></p> <p>The Committee resolved that:</p> <p>a) The contents of the report were noted.</p>	
<p>A&A 25/09/2.3</p>	<p>Procurement Compliance Report (click to view)</p> <p>The Procurement Compliance Report was received.</p> <p>The Deputy Director of Finance (DDF) presented the report, noting a high number of non-compliance cases, particularly related to capital estates and emergency maintenance, which often required urgent procurement and could bypass standard processes.</p> <p>He advised the Committee that there was an upward trend in non-compliance, with 53 breaches already in the current year compared to 63 for the whole of the previous year, however, cautioned that many contracts were signed early in the year, so the trend may not continue at the same rate.</p>	

It was noted that training sessions were being scheduled for areas with high non-compliance, and **a deep dive on procurement compliance was planned for the next Audit Committee meeting.**

The CC expressed concern about recurring non-compliance in the CD&T Clinical Board and Executive areas and raised the issue of retrospective contract terms.

The IMICT questioned how significant sums (e.g., £35,000) could be spent without procurement involvement and asked about limits and controls to prevent unauthorised spending. He requested **more granularity in future reports**, specifically on when procurement became involved and whether proper authorisation was eventually obtained.

The DDF responded that while there were authorisation limits for final payments, sometimes procurement was not involved early enough because delegated areas or Clinical boards managed their own business and could progress procurement activities without realising procurement should be engaged sooner.

He clarified that although procurement may not be involved at the outset, authorisation for payment must still occur at the appropriate seniority level. However, the breakdown often happened when those authorising payments did not check for prior procurement involvement.

The IMICT's concern was acknowledged, and it was agreed that more granularity was needed in future reports to clarify when procurement got involved and to ensure proper sign-off, even if it was retrospective.

The UHB Vice Chair emphasised the need to monitor the effectiveness of training and to see if non-compliance improved as a result.

The Committee resolved that:

- a) The contents of the report were noted and approved/agreed.

**A&A
25/09/2.5**

[Structured Assessment Update \(click to view\)](#)

The Structured Assessment Update was received.

The DCG Matt provided an update to close off the previous structured assessment cycle, referencing Audit Wales' report that the new structured assessment work was now starting.

He highlighted that the appendix provided showed how actions and recommendations from the last assessment had been captured and addressed, using the AMAT system for tracking.

It was noted that one action remained outstanding: the need for a new risk management strategy and that it was delayed because the risk management strategy and policy must follow the ongoing work to transfer all organisational risks into AMAT, as the team was still learning and building the module with the vendor.

The DCG advised the Committee that his Team's priority was to complete the risk transfer by October 2025, with a moderation meeting planned for November 2025.

The CC commented that the recommendations were familiar and clearly being implemented, commending the team's progress.

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	<p>The Committee resolved that:</p> <p>a) The actions and recommendations outlined at Appendix 2 and the ongoing work to complete the actions and recommendations were noted.</p>	
<p>A&A 25/09/2.6</p>	<p><u>Tackling the Planned Care Challenges (click to view)</u></p> <p>The Tackling the Planned Care Challenges report was received.</p> <p>The PAMAW introduced the Audit Wales review on planned care recovery, noting it was part of a national thematic programme across all Welsh Health Boards.</p> <p>He summarised the findings which included:</p> <ul style="list-style-type: none"> • Despite operational improvements, Cardiff and Vale’s approach had not achieved the desired impact on waiting lists, and recent improvements may not be sustainable due to reliance on short-term Welsh Government funding. • There was a need for a longer-term, sustainable plan for clinically and financially viable services, as demand and waiting lists had grown over several years, not just post-pandemic. • Some efficiency improvements were noted but more were needed, and the importance of supporting patients while they waited, especially to prevent harm was highlighted. • Ophthalmology was cited as having better harm detection, but further improvement was needed. <p>The PAMAW advised the Committee that the report outlined nine recommendations, acknowledging that some actions would take until 2026 to fully implement, and stressed the preference for robust, embedded solutions over quick fixes.</p> <p>The Managing Director Planned Care (MDPC) agreed with the PAMAW’s summary and described the scale of the challenge as enormous.</p> <p>She updated the Committee on progress since the report noting that:</p> <ul style="list-style-type: none"> • The waiting list for over 104-week waits had been reduced by a further 50%, with a forecast of 900 patients by the end of Q3. • A dual approach was noted: improving productivity/efficiency (including a new one-year role focused on theatre utilisation in key specialties) and managing the ongoing challenge of recurrent problems with non-recurrent funding. • Progress had been made in ophthalmology, including meeting the cataract list target through a new facility, and ongoing work to sustain improvements. <p>The challenge of balancing immediate pressures with developing sustainable services was stressed by the MDPC, referencing the adoption of ministerial enabling actions and progress on seven of eleven items.</p> <p>The UHB Vice Chair raised the need for more specificity in clinical risk analysis, emphasising that harm was not just about long waits but about urgency and pathway management.</p> <p>The PAMAW agreed, noting ophthalmology as a model for risk-based review and the need for that approach across all specialties.</p>	

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	<p>The MDPC added that clinical validation during waiting was being embedded, starting with ENT and expanding to other specialties, with consultant and therapist time allocated for patient reviews.</p> <p>The CC asked if the recommendations applied to other Health Boards.</p> <p>The PAMAW responded that there was commonality, with most Boards facing similar challenges and balancing short-term and long-term planning.</p> <p>The CC asked the MDPC about the Health Board's maturity in long-term planning and the MDPC responded stating that the Health Board was not as mature as desired due to constant reforecasting, operational pressures, and a small team, but aimed to move toward a more sustainable, long-term approach.</p> <p>The Committee resolved that:</p> <p>a) The Tackling the Planned Care Challenges report was noted.</p>	
A&A 25/09/4.1	<p>Counter Fraud Progress Update</p> <p>The Counter Fraud Progress Update was received.</p> <p>The Committee resolved that:</p> <p>a) The Counter Fraud Progress Update was noted.</p>	
A&A 25/09/5	<p>Agenda for Private Audit and Assurance Committee</p> <p>i. <i>Counter Fraud Progress Update (Confidential – ongoing investigations)</i></p> <p>ii. <i>Health Board Salaries Overpayment Update</i></p>	
A&A 25/09/6	<p>Any Other Business</p> <p>No Other Business was discussed.</p>	
A&A 25/09/7.1	<p>Items to be deferred to Board / Committee</p> <p>Internal Audit reports that were specific to Committees of the Board would be added to the agenda for the relevant Committee for noting and information.</p>	
A&A 25/09/7.2	<p>Date and time of next committee meeting</p> <p>18 November 2025 via MS Teams.</p>	

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Public Action Log
Following Audit & Assurance Committee Meeting
02 September 2025
(Updated for the meeting being held 18 November 2025)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions					
A&A 25/09/2.1	Internal Audit Progress Report	Contract Management Advisory Audit: A combined action plan would be developed with Shared Services and brought to a future committee.	Ian Virgil	18.11.25	COMPLETE The action plan is being developed with NWSSP and input from the Directors of Finance. Will be received by the Committee at February 2026 meeting
A&A 25/09/2.2	Audit Wales Update	Charitable funds audit plan to be presented at the next Committee meeting.	Urvisha Perez/Audit Wales	18.11.25	COMPLETE Work will be completed in November ahead of the 30 January 2026 Charity Commission deadline
A&A 25/09/2.2	Audit Wales Update	Cost savings checklist be circulated to the Corporate Governance team, Board, and Clinical Board leaders,	Matt Phillips	18.11.25	COMPLETE Cost Savings checklist discussed at Exec Reviews.
A&A 25/09/2.4	Post Payment Verification End of Year report 2024/25	Reporting format to be revised and share drafts for feedback before the next report is due	Amanda Legge	18.11.25	COMPLETE Work ongoing to improve format and provide drafts to the Committee
A&A 25/09/2.3	Procurement Compliance Report	Deep dive on procurement compliance for the next Audit Committee meeting	Claire Salisbury	18.11.25	COMPLETE On agenda for meeting 18.11.25
Actions Referred to Board or Committees					

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Report Title:	Internal Audit Progress Report		Agenda Item no.	2.1	
Meeting:	Audit & Assurance	Public	X	Meeting Date:	18/11/25
		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 report has been finalised since the September 25 meeting:

- Deprivation of Liberties Standards (Reasonable Assurance)

The Executive summary of the final report is included within the progress report, with the full version of the report within the committee supporting papers.

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

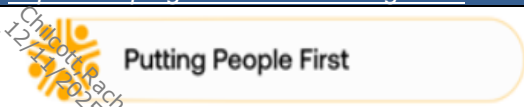
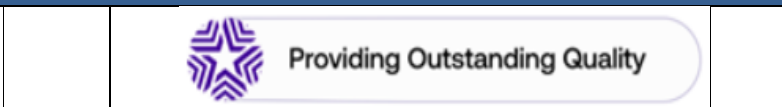
Recommendation:

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 adjustments to the 2025/26 plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

<https://shapingourfuturewellbeing.com/>

 <p>1.</p> <p>Click the objective above to view more detail.</p>	 <p>2.</p> <p>Click the objective above to view more detail.</p>
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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
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Quality Impact Assessment Completed?

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

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:

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Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee November
2025

NWSSP Audit and Assurance Services



glo
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Cydwasaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



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<i>5.Changes to the 2025/26 Internal Audit Plan</i>	<i>4</i>
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Appendix A	Assignment Status Schedule
Appendix B	Report Response Times
Appendix C	Key Performance Indicators
Appendix E	Assurance Ratings

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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 November Audit Committee but did not meet that deadline.

Audit	Current Position	Draft Rating	Reason
Medical Equipment & Devices	Draft Report	Reasonable	Delay in completion of fieldwork due to additional testing and site visits.
ALN Act	Draft Report	Reasonable	Delay in completion of fieldwork due to availability of IA Resources.
Financial Sustainability	Draft Report	Reasonable	Availability of IA resources and requirement for additional testing.
Digital Literacy	Work in Progress		Delay in agreeing scope of audit and then management request to postpone commencement of fieldwork.

3. Outcomes from Completed Audit Reviews

One assignment has been finalised since the previous meeting of the committee and is highlighted in the table below along with the allocated assurance rating.

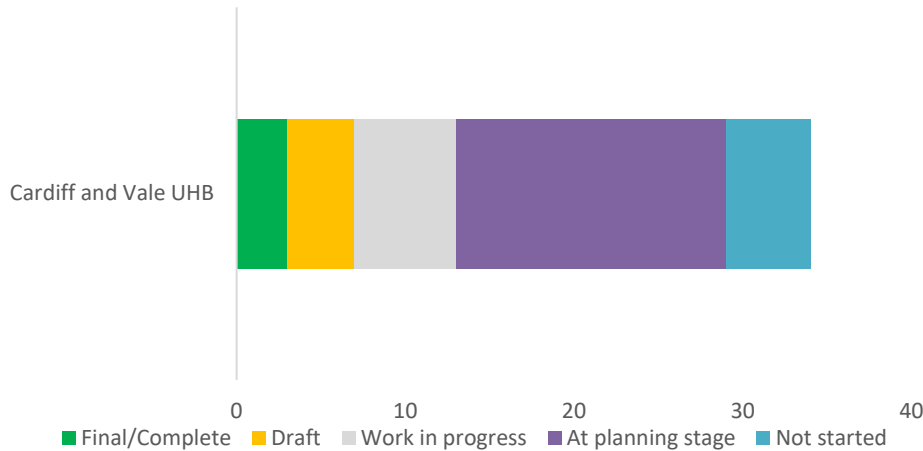
The Executive Summary from the final report is provided in Section six. The full report is included separately within the Committee supporting papers.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Deprivation of Liberties Safeguards (DoLS)	Reasonable	

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4. Delivery of the 2025/26 Internal Audit Plan

There is a total of 34 reviews within the 2025/26 Internal Audit Plan, (including the change highlighted below), and overall progress is summarised below.



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

In addition, there are six audits that are currently work in progress with a further sixteen 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

The planned audit of the Diabetes Care Process has been proposed for deferral from the 25/26 plan due to the current and ongoing introduction of new processes. The deferral has been agreed with the Director of Public Health.

It has been requested that the timing of the 5 Steps to Safer Surgery and Performance Management audits are moved to quarter 4 of the 25/26 plan.

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6. Final Report Summaries

6.1 Deprivation of Liberties Safeguards (DoLS)



Reasonable Assurance

Purpose

The overall objective was to review the arrangements for ensuring compliance with DoLS requirements.

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provides protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to far more people than it had previously, with the number of people subject to DoLS increasing significantly.

In 2019 the law was changed with an amended Mental Capacity Act (2019) (MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). These changes were originally scheduled to replace the DoLS legislation and procedures from 1 October 2020. However, in April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, would be delayed "beyond the life of this Parliament" (therefore beyond Autumn 2024). As such, the existing DoLS policies, rules and regulations are still extant.

Our review was to look at current processes for DoLS applications and ensure they are managed in accordance with DoLS Code of Practice, Welsh Government guidance and Health Board procedures.

Overview

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

- There is currently no DoLS policy in place within the Health Board.
- There is no documented Standard Operating Procedure in place.
- Training on DoLS is not mandated for staff including those who are responsible for identifying DoLS cases and completing applications.
- The number of DoLS assessments required to be completed in an average week is consistently higher than the number of assessments that are being paid for to be undertaken by the Local Authority.

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:

- There are numerous documents relating to DoLS on Sharepoint; however, not all of these are structured within the DoLS specific Sharepoint page and it is not clear which of these are still current and relevant. This has also been identified within the DoLS Work Plan Tracker 2025/26 which includes a 'review of Sharepoint and resources'.
- Reports to and discussions within the Mental Health Legislation Committee could be strengthened with greater focus on the applications that have not been undertaken in the timeframes including trend analysis and data on the number of staff that have been DoLS trained by Clinical Board.

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 policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.	1, 2	Limited
2	Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.	3	Reasonable
3	An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary.	4	Reasonable
4	The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework.		Substantial

Management Actions



High priority



Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

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
Medical Equipment & Devices	09	Allied Health Professionals	2/3		Draft Report	Reasonable	February
Quality & Safety Governance	34	Chief Exec / Chairman	1		Draft Report	Advisory	February
Financial Sustainability	10	Finance	2		Draft Report	Reasonable	February
ALN Act	08	Allied Health Professionals	3		Draft Report	Reasonable	February
Medical Staff Deployment	31	Medical	1		Work in Progress		February
Children and Women CB – Governance Arrangements	25	Chief Operating Officer	2		Work in Progress		February
Clinical Board Adherence to the Managing Attendance at Work Policy	18	People & Culture	1/2		Work in Progress		February
Digital Literacy	07	Digital Health & Intelligence	2/3		Work in Progress		February
Standards of Business Conduct (DOI / G&H)	02	Corporate Governance	3/4		Work in Progress		February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Estates Assurance – Space Utilisation	14	Finance	2		Planning – Final brief issued		February
Implementation of Health Roster Follow-up	15	Nursing	2/3		Planning – Final brief issued		February
GMS Unified Contract Assurance Framework	28	Chief operating Officer	2/3		Planning – Final brief issued		February
Staff Overpayments	11	Finance / People & Culture	3		Planning – Final brief issued		February
Neurodevelopment Services for Adults and Children	27	Chief Operating Officer	4		Planning – Final brief issued		February
Reducing Health Inequalities	22	Public Health	3		Planning – Draft 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		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		May
Planned Care Programme	26	Chief Operating Officer	3/4		Planning		May
Medicines Management	32	Medical	3/4		Planning		May
5 Steps to Safer Surgery	33	Medical	2/3	4	Planning – Draft brief issued		May
Risk Management and Board Assurance Framework	01	Corporate Governance	4				May

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Alcohol Standards Follow-up	03	Public Health	4				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				May
Interventions Not Normally Undertaken Follow-up	21	Public Health	4				May
Approved Integrated Audit & Assurance Plan Assignments:							
Wellbeing Hub Park View	SSU	Finance	2		Work in Progress		February
Pentyrch/Rhydlafer ICRF Health Centre	SSU	Finance	TBC				TBC

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.				

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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

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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	50% 4 from 8	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 8 from 8	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	100% 4 from 4	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 4 from 4	80%	v>20%	10%<v<20%	v<10%

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Assurance Ratings

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

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Deprivation of Liberties Safeguards (DoLS) Final Internal Audit Report 2025/26

Cardiff & Vale University Health Board



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Review Reference
Fieldwork
Executive Sign Off
Audit Committee
Executive Lead
Audit Team

CVU-2526-16
July - August 2025
September 2025
November 2025
Jason Roberts, Executive Director of Nursing
Ian Virgil, Head of Internal Audit
Lucy Jugessur, Deputy Head of Internal Audit

GIG CYMRU NHS ALES
Partneriaeth Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services



Executive Summary

Purpose

The overall objective was to review the arrangements for ensuring compliance with DoLS requirements.

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provides protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to far more people than it had previously, with the number of people subject to DoLS increasing significantly.

In 2019 the law was changed with an amended Mental Capacity Act (2019) (MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). These changes were originally scheduled to replace the DoLS legislation and procedures from 1 October 2020. However, in April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, would be delayed "beyond the life of this Parliament" (therefore beyond Autumn 2024). As such, the existing DoLS policies, rules and regulations are still extant.

Our review was to look at current processes for DoLS applications and ensure they are managed in accordance with DoLS Code of Practice, Welsh Government guidance and Health Board procedures.

Overview

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

- There is currently no DoLS policy in place within the Health Board.
- There is no documented Standard Operating Procedure in place.
- Training on DoLS is not mandated for staff including those who are responsible for identifying DoLS cases and completing applications.
- The number of DoLS assessments required to be completed in an average week is consistently higher than the number of assessments that are being paid for to be undertaken by the Local Authority.

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:

- There are numerous documents relating to DoLS on Sharepoint; however, not all of these are structured within the DoLS specific Sharepoint page and it is not clear which of these are still current and relevant. This has also been identified within the DoLS Work Plan Tracker 2025/26 which includes a 'review of Sharepoint and resources'.
- Reports to and discussions within the Mental Health Legislation Committee could be strengthened with greater focus on the applications that have not been undertaken in the timeframes including trend analysis and data on the number of staff that have been DoLS trained by Clinical Board.

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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

	Objectives	Related Findings	Assurance
1	The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.	1, 2	Limited
2	Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.	3	Reasonable
3	An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary.	4	Reasonable
4	The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework.		Substantial

Management Actions

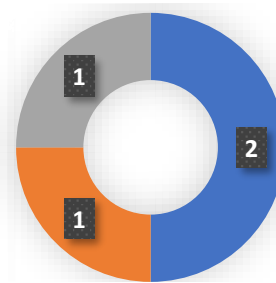


High priority



Medium Priority

Themes



■ Policies & Procedures

■ Resourcing

■ Training & Development

Risk Types

Legal & Regulatory Non-Compliance

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Findings & Agreed Action Plan

Objective 1: The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.

Limited

Overview / Summary of Observations

The Health Board does not currently have a documented policy or procedure covering DoLS. The Health Board's Sharepoint site holds several documents including various guides and training materials that provide an overview of the DoLS processes employed. However, this gives a fractured view without illustrating the full end-to-end process. Furthermore, the available resources do not sufficiently detail the roles and responsibilities of all involved with an application or clearly detail the timeline targets for the processing of DoLS applications.

Whilst there are numerous documents on DoLS available on Sharepoint, they are not all consolidated on the DoLS specific intranet page, and it is not clear which of these remain current and relevant and which may be out of date or have been replaced.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 The Health Board does not have a DoLS policy</p> <p>The Health Board does not have a specific policy on DoLS in line with the Welsh Government guidance.</p> <p>Whilst the Welsh Government guidance provides the benchmark, this should be translated into standardised guidance in the form of a policy that as a minimum:</p> <ul style="list-style-type: none"> Explains the Health Board's objectives regarding DoLS; Provides clarity over roles and responsibilities with regards to DoLS within the Health Board; and Ensures alignment between the Health Board's operating procedures and mandated legislation. <p>Previous audits undertaken within two other Health Boards identified that they have specific DoLS policies in place.</p>	<p>Absence of an up-to-date policy may risk non-compliance with legislation and/or best practice guidance</p>	<p>Suggested Action:</p> <p>A DoLS policy will be written, reviewed, approved and implemented. The policy will align to Welsh Government and best practice standards.</p> <p>Expected Evidence of Implementation:</p> <p>An approved DoLS policy will be available on the Health Board Sharepoint site.</p>
<p>Theme: Policies & Procedures</p>	<p>High Priority</p> <p>Control Design</p>	<p>Officer: Chloe Evans, MCA Project Lead</p> <p>Target Implementation Date: March 2026</p>

<p>2</p>	<p>The Health Board does not have a Standard Operating Procedure on DoLS</p> <p>The Health Board has several documents describing the DoLS process including guides and training materials. Whilst useful, these documents do not describe the full end-to-end procedure and associated target timelines. However, it was recognised in the Mental Capacity Act (MCA) Team’s formal DoLS Work Plan Tracker 2025/26 that a formal procedure document is to be produced, and this will commence in August 2025.</p> <p>The aforementioned previous audits also identified that the two Health Boards have documented DoLS procedures in place.</p>	<p>Absence of up-to-date procedures may risk non-compliance with legislation and/or best practice guidance</p>	<p>Suggested Action:</p> <p>A DoLS procedure document will be produced to illustrate and explain the full end-to-end procedure for DoLS to provide staff with a clear overall view.</p>
		<p>Medium Priority</p>	<p>Expected Evidence of Implementation:</p> <p>An approved DoLS procedure will be available on the Health Board Sharepoint site.</p>
	<p>Theme: Policies & Procedures</p>	<p>Control Design</p>	<p>Officer: Chloe Evans, MCA Project Lead</p> <p>Target Implementation Date: March 2026</p>

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Overview / Summary of Observations

Training on DoLS is not mandated for Health Board staff. Instead, attendance is left to the discretion of individual staff and ward managers. This has resulted in historically, a low uptake of training. Feedback from the Mental Capacity Act (MCA) team suggests two potential issues as a result:

- 1) Low confidence that DoLS scenarios are being correctly identified on wards, potentially resulting in patients being unlawfully deprived of liberty; and
- 2) Application form quality is inconsistent, and errors can result in administrative delays.

To address these points, a new face-to-face training programme was launched in April 2025 and attendance at these sessions has steadily increased following an MCA team drive to promote this training. Records show that whilst 37 staff attended training in Quarter 1, this has increased to 103 staff booked to attend sessions in Quarter 2.

During the audit review, DoLS training was added as a non-mandatory requirement to ESR. This change will provide greater transparency over training statistics, enabling analysis of the number of staff trained across different clinical areas and wards, which in turn will assist with the ability to report numbers of DoLS trained staff. Training records from April to July 2025 need to be uploaded to ESR now that the module is available and the MCA Team have confirmed they are targeting completion of this by end of August 2025.

We visited three wards during the audit, and the following was noted:

- 1) At least one team member was trained on DoLS (however in one ward, there was only one staff member that had been trained);
- 2) Materials promoting DoLS awareness and training sessions were available on the wards visited;
- 3) Staff stated that there had been a noticeable improvement in DoLS resources and support available to them; and
- 4) Staff were generally able to explain the DoLS process however, there remained some challenges in recognising DoLS scenarios and in completing application forms. This is consistent with the feedback received from the MCA Team as noted above.

We acknowledge that the MCA team have made significant advances in training and awareness through the calendar year, and this can be demonstrated with the team's "DoLS workplan tracker". This ten-point action plan was compiled in response to an annual self-assessment audit conducted by the MCA team most recently in Quarter 3 of 2024-25 with the focus primarily on awareness and training improvements. The plan is actively managed showing completion of six of the ten actions and evidence of the impact of these actions was noted through our audit.

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Key Findings	Risk & Impact	Agreed Management Action
<p>3 DoLS training is not mandatory</p> <p>DoLS training is not mandatory for staff in the Health Board. Instead, training is optional, and completion is left to the discretion of individual staff members and their ward managers. This has resulted in a low number of staff being trained on DoLS and this was substantiated by our ward visits whereby one ward had only one trained staff member.</p> <p>Ward Managers highlighted that DoLS training can be challenging to manage as it is not recorded on ESR. In two of the three wards visited, ward managers could not confirm the number of staff trained.</p> <p>We reviewed DoLS training in two other Health Boards and found that DoLS training was mandatory for ward staff in both.</p>	<p>Non-compliance with policy or legislative standards causing patient distress and potential for Board complaints and compensation liabilities.</p>	<p>Suggested Action:</p> <p>A training strategy will be developed that considers how DoLS training should be implemented across the UHB within available resource. This will consider different approaches such as: the use of a staged approach to target key staff i.e. ward managers and deputy ward managers (with dissemination of learning through clinical teams), hybrid training, support from ECOD.</p> <p>A scoping exercise will be undertaken to identify what has worked well in other organisations.</p> <p>Expected Evidence of Implementation:</p> <p>Improvement in the number of staff trained in DoLS. This will be monitored on a monthly basis and fed back to clinical boards along with MCA Training compliance figures.</p>
<p>Theme: Training & Development</p>	<p>Medium Priority</p> <p>Control Design</p>	<p>Officer: Chloe Evans, MCA Project Lead</p> <p>Target Implementation Date: March 2026</p>

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Objective 3: An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary.

Reasonable

Overview / Summary of Observations

The Health Board contract DoLS assessments from the Local Authority by way of a tripartite agreement. Through this agreement, the Health Board pay for six assessments per week from the Local Authority. However, this capacity was temporarily extended by an additional five assessments per week, to 11 in total on 7 July 2025, which is ongoing but is not currently funded. The increase was due to the number of assessments that were breaching timelines.

In Quarter 1 2025-26, the Health Board submitted 439 applications. Of these, 311 were withdrawn with the remainder (128) requiring assessment. Based on these figures and averaging across the 13 weeks in a quarter; increasing the number of paid for assessments to 11 per week is appropriate.

A database of DoLS applications is maintained by the MCA Team via a spreadsheet. This is updated daily with logs made for new applications and progress updates recorded for existing ones. We reviewed this database and noted the following:

- Updates are recorded daily so that the database is constantly up-to-date and accurate;
- Every application had a record of the patient, assessor and signatory providing traceability of all individuals involved with the process;
- File notes were recorded making it possible to identify exactly where in the process every application was at a given point in time; and
- The database contained automated calculations to display how long the various stages of the process had taken.

We reviewed a random sample of 27 completed assessments selected from Quarter 1 2025-26 (60% of total). Of these, only six had been completed within the mandated timescales. We noted the following observations during our review:

- 22 of the 27 assessments were for "Urgent" referrals. Of these, only three had been completed within the mandated 7-day timeframe.
- Five of the 27 assessments were for "Standard" or "Further" referrals. Of these, three had been completed within the mandated 21-day timeframe.
- The average amount of time taken to allocate a Mental Health Assessor for all 27 assessments was 27 days.

For those assessments that breached timescales, delays were noted at all stages of the process but, analysis as detailed above shows that the critical delay resulting in breach was that of allocating a Mental Health Assessor (MHA).

For all assessments reviewed, the files contained all required paperwork. Furthermore, all paperwork had been completed to a high standard, supporting the ultimate approval decision. All DoLS applications had been approved by the approved signatories for DoLS.

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Key Findings	Risk & Impact	Agreed Management Action
<p>4 Assessment time breaches</p> <p>Whilst the database managed by the MCA Team is accurately maintained, it consistently shows assessments to be breaching the mandated timescales for completion.</p> <p>The Health Board participate in a tripartite agreement through which, six assessments per week are paid for. This was temporarily extended on 7 July to 11 assessments per week with the additional capacity provided by an agency.</p> <p>With an average of ten assessments required per week through Quarter 1 of 2025-26, the baseline of six is insufficient for volumes required. This is demonstrated by the following breakdown of assessments required in the months of Quarter 1:</p> <ul style="list-style-type: none"> • April – 48. • May – 36. • June – 44. <p>We acknowledge that the MCA Team have submitted business cases requesting additional funding and that to date, these have not been approved.</p>	<p>DoLS applications are not submitted/logged/actioned according to mandated standard resulting in possible unlawful deprivation of patient liberty.</p>	<p>Suggested Action:</p> <p>Management will revise and re-submit their business case requesting additional funding to be made permanent, based on comparison of assessment data between Quarter 2 and Quarter 1.</p>
	<p>Medium Priority</p>	<p>Expected Evidence of Implementation:</p> <p>A revised business case will be produced requesting the additional funding.</p>
<p>Theme: Resourcing</p>	<p>Control Design</p>	<p>Officer: Jason Roberts, Executive Director of Nursing and Chloe Evans, MCA Project Lead</p> <p>Target Implementation Date: January 2026</p>

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Objective 4: The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework.

Substantial

Overview / Summary of Observations

The MCA Team maintain an accurate database of all applications and their status. As well as providing a robust overview of operational activity at any given point in time, the data provides the basis for monthly performance meetings between the Health Board MCA Team and Local Authority (LA) DoLS Team. In addition, the Local Authority also submit a weekly breakdown of assessments conducted via an agency. This supplementary report provides transparency over the additionally commissioned assessments the Health Board is currently contracting.

The monthly performance review meetings allow opportunity to discuss and challenge activity recorded on the live database and the supplementary report provide assurance that the commissioning arrangement with the LA is being actively managed and constantly assessed to ensure value for money.

Quarterly activity reports are produced by the Local Authority and submitted to the MCA Team. These reports detail all applications submitted during the quarter and an up-to-date status for each, effectively summarising the data maintained on the MCA Teams database. This report is submitted to both the Safeguarding Steering Group and the Mental Health Legislation Committee and is presented by the MCA Lead/Director of Nursing at Committee meetings. The report includes a breakdown of all activity KPIs including measures covering applications and assessments.

We reviewed the minutes and video recordings of the Mental Health Legislation Committee meeting from 29 April 2025. To improve transparency for Committee members on DoLS operational performance, we have suggested some minor improvements in the Executive Summary section of this MCA DoLS report.

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Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

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

Public Sector Internal Audit Standards

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



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

Date issued: November 2025

Chilcott, Rachel
12/11/2025 16:38:12

This document has been prepared for the internal use of Cardiff and Vale University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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About this document

- 1 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. We presented our most recent Audit Plan to the committee in May 2025.
- 2 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.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Chilcott, Rachel
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Financial audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2024-25 Charitable Funds Accounts	Executive Director of Finance	To provide an audit opinion on the Health Board's Charitable Funds Accounts.	Audit work ongoing.	Work to be completed in November ahead of the 30 January 2026 Charity Commission deadline.
Audit of the 2025-26 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2025-26 Annual Report and Accounts.	Planning and interim testing to commence over autumn/winter	Certification deadline of 30 June 2026

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Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 – core	Director of Corporate Governance	<p>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 will review:</p> <ul style="list-style-type: none"> • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. 	Report drafting	February 2026
Structured Assessment 2024 Deeper Dive -	Director of Digital and	This review will examine digital arrangements, with a particular focus on how the Health Board is investing in digital	Fieldwork underway	To be confirmed

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of Digital Transformation	Health Intelligence	technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.		
Review of eye care services (2024 local work)	Chief Operating Officer	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 Health Board is supporting patients to minimise the risk of harm occurring as a result of delays in access.	Report drafting	February 2026
Structured Assessment 2025 Deeper Dive - Review of the arrangements to manage estates	To be confirmed	This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on ensuring the current estate is fit for purpose, represents value for money and supports the organisation's wider strategic priorities.	Planning	To be confirmed

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Review of cancer services	To be confirmed	<p>This work will follow on from the <u>Review of National Leadership Arrangements for Cancer Services</u>.</p> <p>Whilst the exact focus of this work is to be determined, it is likely to consider:</p> <ul style="list-style-type: none"> • 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. 	Planning	To be confirmed
Progress review: 2019 Clinical Coding Follow-up Review (Local work 2025)	Chief Operating Officer	This work will focus on reviewing the Health Board's progress in addressing the recommendations made in our <u>2019 clinical coding follow-up review</u> , which was a follow-up of the work completed in <u>2014</u> .	Fieldwork underway	To be confirmed

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Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
<u>NHS Wales Finances Data Tool</u>	September 2025
<u>Temporary Accommodation, long-term crisis?</u>	July 2025
<u>Cost Savings Arrangements – A checklist for NHS Board Members</u>	June 2025

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. The links to the reports on our website are provided.

Title	Publication Date
<u>Interim Report 2025-26</u>	November 2025
<u>Estimate of Income and Expenses for the year ended 31 March 2027 (supporting information)</u>	November 2025
<u>Equality Report 2024-25</u>	October 2025

- 8 There are no relevant Audit Wales consultations currently underway.

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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.

National Fraud Initiative 2024-25: update for Cardiff and Vale University Health Board

About the National Fraud Initiative

- 1 The National Fraud Initiative (NFI) is a biennial UK-wide counter-fraud exercise. It helps prevent and detect fraud by electronically sharing and matching data sets. **Appendix 1** provides further information on how the NFI works.
- 2 In Wales, the NFI operates under the Auditor General's statutory powers. Participation is mandatory for unitary local authorities, NHS bodies, police forces, and fire and rescue authorities. Participating on a voluntary basis in the latest exercise are the Welsh Government, some Welsh Government arm's length bodies (Natural Resources Wales, Arts Council of Wales, Sport Wales, National Library of Wales, Transport for Wales), and South East Wales Corporate Joint Committee.
- 3 This briefing note provides an update on the latest NFI 2024-25 exercise at a national level and as at 31 July 2025. It also provides some local level data for your organisation, although we are encouraging those charged with governance to seek further local detail from lead officers.

Data submission for 2024-25

- 4 The NFI 2024-25 exercise is underway. Participants submitted data for the biennial batch data matching exercise in October 2024. This included data on housing benefits, housing tenants and waiting lists, blue badge parking permits, licences, and various payments such as creditor payments, payroll, and pensions.
- 5 The UK Public Sector Fraud Authority released most data match reports to participants by the end of December 2024. Council tax and electoral register data are submitted annually. The most recent deadline for submitting this data was February 2025.
- 6 Supplementary data runs take place during the exercise to process new, incomplete or missing data submissions. For example, progress is being made to amend the Public Audit (Wales) Act 2004 through a Legislative Reform Order which will enable the NFI to resume the matching of adult social care data during the NFI 2024-25 exercise.

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National update

Data matches and investigation

- 7 To date, almost 440,000 data matches have been identified for the Welsh NFI 2024-25 exercise participants. **Exhibit 1** shows that most of these matches are for unitary authorities and health bodies.

Exhibit 1: NFI 2024-25 Welsh participant data matches by type of organisation, at end of July 2025

Type of organisation	Number of data matches	% of data matches
Unitary authority	373,114	84.9
Health	50,409	11.5
Police	2,641	0.6
Fire and rescue	740	0.2
Other	12,749	2.9
Total	439,653	100.0

Source: Audit Wales analysis of NFI web-application data

Note: % total does not match the sum of the parts due to rounding.

- 8 Data matching identifies potentially fraudulent or erroneous claims and payments. No assumption can be made about whether there is fraud, error, or another explanation until an investigation is carried out. There can, for example, be false positives around creditor payments if bodies are deliberately making staged payments of the same amount.
- 9 We recognise it is not practical to investigate all data matches, particularly for bodies with large numbers of matches. Bodies are encouraged to take a risk-based approach to assessing data match reports and deciding what type of, and how many, data matches they review.
- 10 By the end of July 2025, five participating bodies had not yet closed any data matches. Some participants are making good progress with reviewing NFI 2024-25 data matches, while others have made limited progress.
- 11 **Exhibit 2** shows the total number of data matches for each data match area. It also shows the number of data matches closed in a data match area, along with the number of participants that have matches in that area.

The absence of closed matches indicates that the participant has not reviewed any matches in that area.

Exhibit 2: NFI 2024-25 Welsh participant data matches processed and closed, at end of July 2025

Data match area	Data matches	Data matches closed	Participants with data matches	Participants with no closed statuses for their matches
Council tax single person discount	198,146	5,385	22	11
Creditors	187,228	19,791	48	16
Council tax reduction scheme	16,578	3,547	22	1
Blue badges	10,377	5,849	22	3
Payroll	8,150	1,705	46	6
Housing waiting lists	6,359	1,392	18	5
Housing tenants	4,636	879	11	2
Pensions	2,962	1,098	12	4
Resident parking	2,405	2,368	8	1
Procurement	1,985	400	42	28
Housing benefit	826	483	22	2
Taxi drivers	1	1	1	0
Total	439,653	42,898	49	5

Source: Audit Wales analysis of NFI web-application data

Note: After risk assessing data match reports and any subsequent investigations, each data match should be 'closed' and given a match status. There are a range of 'closed' statuses. Matches not investigated should be given the status 'Closed – Not selected for investigation'. Assigning match statuses to data matches can be done individually or by bulk selection.

Outcomes

- 12 Welsh participants recorded outcomes of £4.7 million for the period 1 April 2024 to 31 July 2025. **Exhibit 3** shows which matching process the outcomes relate to.

Exhibit 3: Welsh participant reported NFI outcomes, 1 April 2024 to 31 July 2025

NFI exercise	Outcomes (£s)
NFI 2024-25 biennial exercise	1,719,037
Late savings from the NFI 2022-23 biennial exercise	867,157
Annual council tax data matching exercises	2,080,831
Total	4,667,025

Source: Audit Wales analysis of NFI web-application data

Note: Outcomes are made up of (i) actual amounts participants have recorded as fraud or error; and (ii) estimated elements which seek to capture the value of loss from a fraud or error detected, and the value of any future losses that bodies may have incurred without intervention following an NFI match. Most datasets have a methodology to calculate estimated savings. All methodologies are reviewed by the Cabinet Office's NFI Governance Board and approved by the Cabinet Office's Fraud Prevention Panel.

Local update

- 13 Data matches are released in data match reports. Each report has a different purpose and compares data from two or more datasets. The reports are broken down into dataset types: for example, housing benefit, payroll, or creditors.
- 14 An organisation's risk assessment of the data match reports should determine the types and numbers of data matches to be investigated. To aid risk assessment, the NFI web application flags some data match reports as 'key reports' with historically high success rates in identifying fraud or error. Also, most individual data matches are assigned a fraud risk score.
- 15 **Exhibit 4** shows the total number of data matches identified for Cardiff and Vale University Health Board, along with those recorded in key reports. **Appendix 2** provides some further analysis of these data matches by fraud risk score.

Exhibit 4: Cardiff and Vale University Health Board’s NFI 2024-25 data matches, at end of July 2025

Data match area	Data matches in all reports	Data matches in key reports with historically high success rates
Creditors	2,613	1,457
Payroll	425	293
Procurement	31	31
Total	3,069	1,781

Source: Audit Wales analysis of NFI web-application data

Note: Council tax single person discount data match reports are not formally designated as ‘key reports’ but are treated as such in practice.

- 16 Various factors can influence which data match reports are reviewed and when this takes place. For example, an organisation may prioritise looking at data match reports linked to areas where it has concerns about internal controls or where there is a history of fraud or error. Also, local resourcing will dictate the pace of progress. For these reasons, this general update does not provide further detail on where processing work and outcomes are recorded by your organisation at this stage.
- 17 The NFI web application features a dashboard and provides various reports on outcomes and processing activity. We encourage those charged with governance to seek more detailed updates on processing work and outcomes recorded from their NFI Senior Responsible Officer and NFI Key Contact.

Future Audit Wales work

- 18 For this NFI exercise we will carry out a high-level assessment of participants’ governance and follow-up arrangements. We will engage with bodies over the autumn/early winter to consider issues covered in our NFI self-appraisal checklist.¹ We will also analyse the risk assessment and data

¹ In December 2024, we shared the updated checklist with NFI senior responsible officers and key contacts. We encouraged all bodies to complete it and share it with those charged with governance.

match processing work carried out, and the outcomes recorded by participants, as reflected in the NFI web application.

- 19 This work will help us understand the factors influencing the outcomes reported by individual bodies and the variations between them. Findings from this assessment will inform our next national report in autumn 2026.

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Appendix 1 – The National Fraud Initiative

The NFI uses data matching to detect and prevent fraud. It electronically compares sets of data against other records held by the same and other bodies, to see to what extent they match.

The data matching flags anomalies or inconsistencies that indicate potential fraud or error. Indicators of potential fraud are reported to the participants, who are responsible for following up these matches.

The effectiveness of the NFI depends on the thoroughness of the assessment and investigation of matches and recording of outcomes.

Bodies record the outcomes in the NFI web application. Each participant body has a nominated Senior Responsible Owner and Key Contact for the NFI, who in some cases may be the same individual.

The UK Public Sector Fraud Authority, part of the UK Government's Cabinet Office and HM Treasury, oversees the NFI across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales.

We published a report on the outcomes from the 2022-23 NFI exercise in October 2024. Reports on the NFI for other parts of the UK are produced by the Public Sector Fraud Authority, Audit Scotland, and the Northern Ireland Audit Office.

There is no direct cost to participants for taking part in the exercise. Audit Wales receives funding, through the Welsh Consolidated Fund, to pay for bodies to participate in the NFI. This covers the central data matching processing for the biennial exercise, as well as the annual exercise for council tax and electoral register datasets. This remained the case for the NFI 2024-25 exercise. The main costs to participants are, therefore, the resources used to submit data and conduct follow-up work once data matches are released.

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Appendix 2 – Analysis of data matches by fraud risk score for Cardiff and Vale University Health Board

The NFI assigns a fraud risk score of very high risk, high risk, or medium risk to most, but not all, data matches. This risk score is based on a combination of two factors:

- Risk logic – a set of criteria for each dataset combination that, when met, indicates a fraudulent outcome is more likely to occur.
- Footprint score – the number of times an individual in a match appears at the address across all NFI data. It is an indicator of whether that person resides at that address.

Exhibit 5 and **Exhibit 6** provide further analysis of Cardiff and Vale University Health Board's data matches by risk score for data matches in all data match reports and those in key reports. This analysis builds on **Exhibit 4** in the main body of this briefing note. Not all data matches are formally assigned a risk score. Council tax single person discount data matches and matches in key reports that are not formally assigned a risk score should generally be treated as 'very high risk' in practice.

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Exhibit 5: Cardiff and Vale University Health Board's NFI 2024-25 data matches by risk score for data matches in all reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	2,613	211	2,402	0	0
Payroll	425	45	127	122	131
Procurement	31	0	0	0	31
Total	3,069	256	2,529	122	162

Source: Audit Wales analysis of NFI web-application data

Exhibit 6: Cardiff and Vale University Health Board's NFI 2024-25 data matches by risk score for data matches in key reports, at end of July 2025

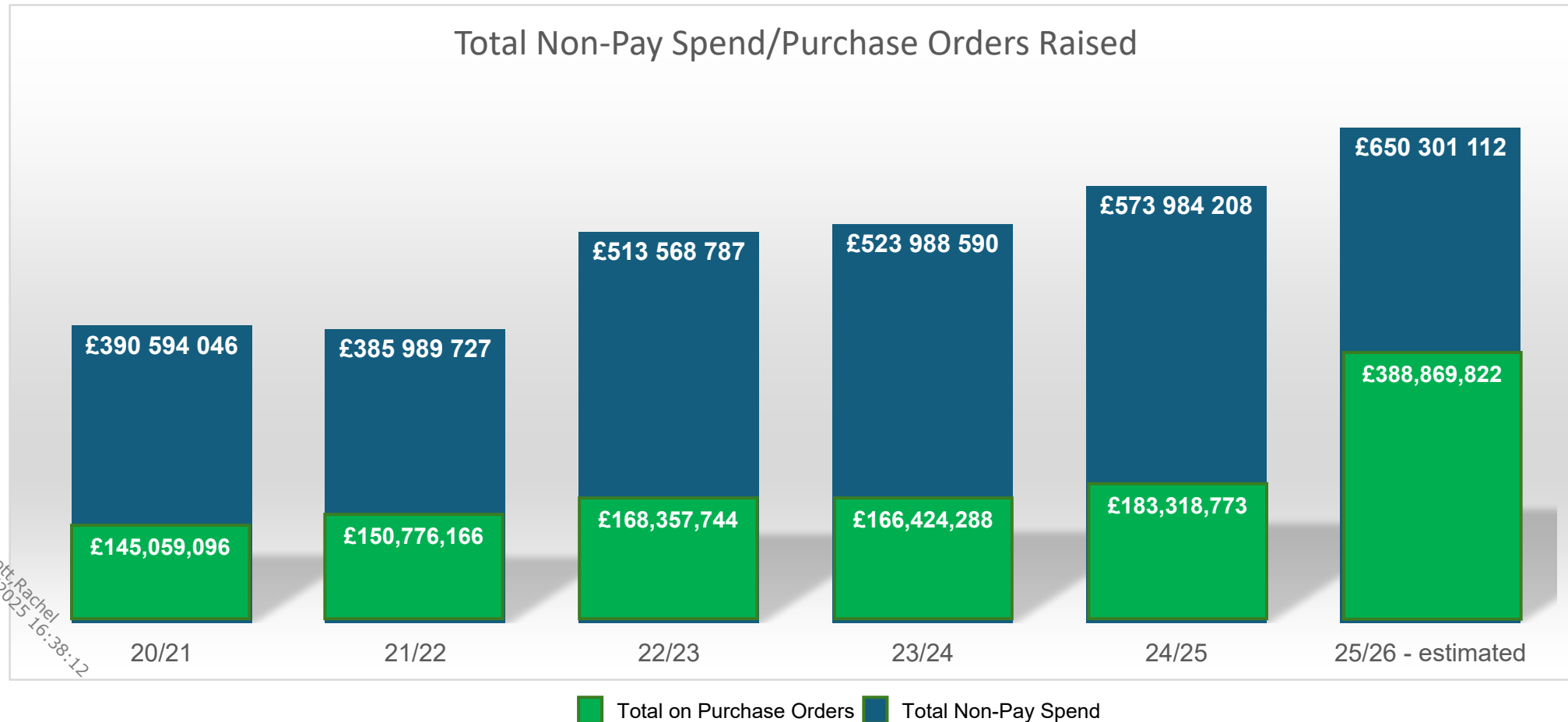
Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	1,457	207	1,250	0	0
Payroll	293	43	35	88	127
Procurement	31	0	0	0	31
Total number of data matches	1,781	250	1,285	88	158

Source: Audit Wales analysis of NFI web-application data

Deep Dive Procurement Services Integrated Partnership CAV

Chilcott, Rachel
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Overview Trend Analysis



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Overview Trend Analysis

	Total Non-Pay Spend	Unable to influence	Manual Payment (contracted)	Total Value of Purchase Orders	Opportunity
20/21	£390,594,046	£103,290,001	£102,355,374	£145,059,096	£39,889,575
21/22	£385,989,727	£119,707,409	£49,226,345	£150,776,166	£66,279,807
22/23	£513,568,787	£118,411,172	£191,954,801	£168,357,744	£34,845,070
23/24	£523,988,590	£141,925,277	£208,761,896	£166,424,288	£6,877,129
24/25	£573,984,208	£128,536,149	£219,929,203	£183,318,773	£42,200,083
25/26 - estimated	£650,301,112	£169,966,346	£261,431,290	£388,869,822	£3,000,000

Unable to Influence:-

- Rates
- some CHC
- Rent
- Legal Fees and Negligence
- Services from other Authorities
- Junior medical training

Manual Payment :-

- Some CHC
- Gas
- Electricity
- Drugs
- Blood/Plasma
- Vaccines

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Improvements to CHC P2P Process

Background

Need to Capture CHC spend
169 homes/supplier led
221 placements of health led
Total annual value £107.977m

Proposed Change

Move to Purchase Orders to enable;
Visibility of committed spend
Streamlined invoice matching and payment
Spend analysis
Performance monitoring

Work Completed

Accurate Suppliers set up on Oracle
Blanket Purchase Orders created using forecasted figures
Discussions held with Finance to support change

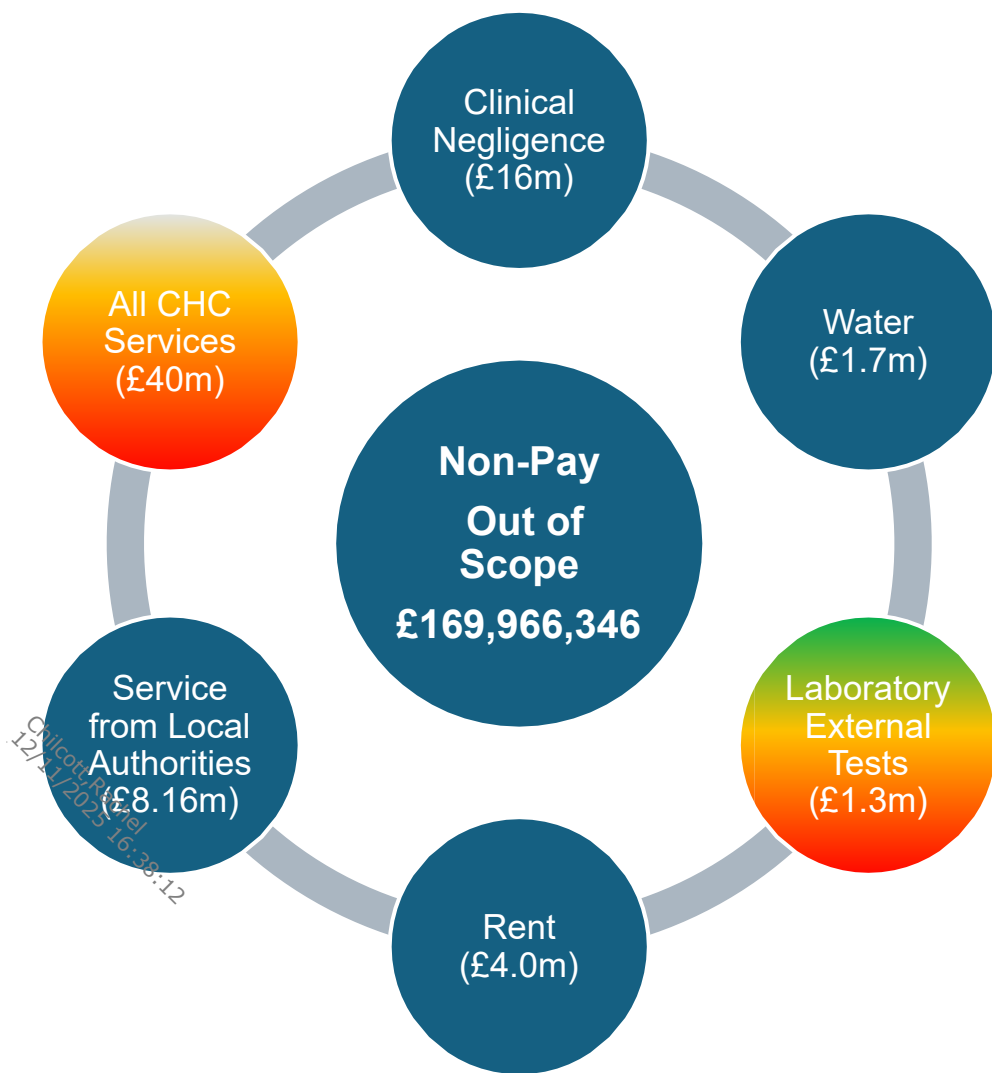
Benefits

Future compliance of SFIs/legislation in relation to P2P
Improved budgetary control/visibility
Mitigate overspend where possible
Support internal controls & Accountability
Data Intelligence

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Procurement Influence



Limited Procurement Influence

£3,038,684

examples;

- Advertising (£190k)
- Dressings (£174k)
- M&S Disposables (£1.3m)
- Translation Costs (£620k)

What's next? Already in scope

Update/Training on Procurement Act, PSR regs – provide an opportunity for clinical teams to query future planning projects in readiness.

Digital Services i.e. Use of Artificial Intelligence

Cross departmental schemes i.e. capital/construction sites

Review of **variation of clinical products** within categories using AdviseInc (i.e. Stents, pacing etc)

Greater focus and influence on **repetitive revenue** expenditure

Develop **Estates consumables contracts**, where Procurement have had little influence i.e. electrical, plumbing, heating, mechanical, building materials, etc.

Enhance **supply chain resilience and risk management**, i.e National Stocked Product Range

Review of **courier services/secure transport** within HB and look to aggregate with single supplier

Income Generation – Theatre space currently not in use in UHL – leasing clinical space to private charity, providing better access to care and services for all South Wales patients, whilst generating income for the Health Board.

Report Title:	Procurement Compliance Report			Agenda Item no.	2.4
Meeting:	Audit Committee	Public	X	Meeting Date:	18.11.25
		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 Board/Committee:

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (15)

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
Westpoint van invoices,	£10,808.59	31/08/25 to 31/10/25	Capital Planning Estates and Facilities	Procurement involvement on 20/08/25 and an approach agreed meanwhile, the service changed their strategy incurring the delay.	Van ownership being transferred to Cardiff Council and, as an interim, the leases were extended on a month-by-month basis. Procurement to establish

					a 6-month contract on a direct award basis for compliance.
Platinum Upgrade Kit Article	£5,808.80	One-off Requirement	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.	One off requirement but have emphasised Procurement involvement and be notified earlier in the process to obtain compliance.
SSC Secure Transport	£7,280.00	August 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.	Meet with end users to establish a formal contract for compliance.
FTP placement at Meddygfa Canna Surgery	£10,010.00	01/09/25 to 23/01/26	Capital Planning Estates and Facilities	No Procurement involvement until receipt of the requisition on 02/09/25.	Funded placement via HEIW. Met with HEIW to understand their process and re-enforced Procurement's involvement prior to agreeing future placements.
Payment of Myriad Invoices	£24,750.00	Retrospective	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.	Procurement to review ongoing requirements with Clinical Board. Transparency Notice to be published and contract awarded for future requirements
Reagent Kits MRC Holland	£7,200.00	One-off Requirement	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.	Transparency Notice published and Contract awarded for all future activity
Payment of Veritas Intercontinental SLU	£7,008.00	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.	Procurement to review ongoing requirements with Clinical Board
University Fees - 2025/2026 - Programme Code FZFIRE501 - Bachelor of Engineerin	£141.50	One-off Requirement	Executives	No initial Procurement involvement until the request was received.	Procurement to review ongoing requirements with Clinical Board.

g with Honours in Fire Engineering					
Supply and Installation of kit	£12,284.97	Retrospective	Capital Planning Estates and Facilities	No initial Procurement involvement until requisition was received.	Procurement to discuss maintenance arrangements with supplier and establish formal contract.
Spectra Optia Connect IDL	£10,721.76	April 2025 to March 2026	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 to review ongoing requirements with Clinical Board.
Biotronik ICD - Intica New 7 VR T DF-1 PROMRI	£32,673.00	September 2025	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 to review ongoing requirements with Clinical Board.
UHW Theatre 10 Scrub Tap Replacement of x3. Theatre Sensor Flow Scrub Taps	£6,570.00	Retrospective	Capital Planning Estates and Facilities	No initial Procurement involvement until requisition was raised.	Procurement to provide refresher training to CEF on SFIs and when to engage with Procurement and establishing a consumables framework for ongoing requirements.
Clearpoint neurongs - Exchangeable device	£19,088.16	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 to provide refresher training to Specialist on SFIs and when to engage with Procurement.
Days Rental of vehicles	£45,979.42	October 24 to October 25	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 in discussions with Clin Eng on getting contract in place and currently reviewing purchase v lease options.
Additional value for Agency Staff to support ND WLI that are outstanding	£6,007.47	One-off Requirement	Children and 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.	Additional value to existing contract.

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (4)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Uplift for contract - recyclable and bulky waste collection	£210,000.00	2025	April 2025 - May 2025	Capital Planning Estates and Facilities	Increase in contract activity outside of original scope to include the legislation for additional waste and segregation and associated collection bins across the multiple sites	Uplift in contract value via CCN
Forward Waste Invoicing Costs	£11,500.00	2025	August 2025 - November 2025	Capital Planning Estates and Facilities	Increase in contract activity outside of original scope as outlined above.	Uplift in contract value
Extension of Hire Contract 010002086 5 for 14 X2 Coolbreeze 50B Split Air Conditioner	£7,525.00	01.10.25	2/10/25-7/1/26	Capital Planning Estates and Facilities	Contract extended at risk due to supply delays with the replacement air conditioning units.	Emergency request to extend hire for a further 4 months
Additional value for Agency Staff to support ND WLI that are outstanding	£6,007.47	2025	1 month	Children and Women	Contract breach Value	Line added to PO to cover additional value invoiced

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
Sunchip 2 Open Set	£22,005.00	One-off Requirement	Children and Women	Emergency Activity	Unplanned emergency requirement with no time to put a contract in place.
Urgent Equipment for Physiotherapy Patients	£7,160.00	One-off Requirement	Clinical Diagnostics & Therapies	Emergency Activity	Informed department to involve procurement services while funding is getting approved as we can run exercise concurrently
Radiopharmaceuticals - Datscan	£14,655.00	One-off Requirement	Clinical Diagnostics & Therapies	Unforeseen/Unplanned circumstances	Review of activity, contract was not renewed due to closure of unit – Procurement to link in with service to determine future requirements and align to contract
PHS Group, Cleaning and Sanitary Service	£5,132.92	One-off Requirement	AWMGS	Unplanned, emergency requirement. No contract in place	Reminder to department to engage procurement prior to raising requisition

Supply and Fit HESQ9059LK Heat Exchanger Plate in Theatre Plant Room	£7,462.50	October 25	Capital Planning Estates and Facilities	Unplanned, emergency requirement	Emergency replacement part needed. Without this, all theatres would have to close
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Exemptions (5) (Permitted within SFI's)

Title	Value at Risk	Length Risk/Breach at	Clinical Board	Reason	Action /Status
Lease Rent 2025/26 Whitchurch MC, Sachville Avenue (Assura Aspire Ltd)	£136,260.00	One-off Requirement	Capital Planning Estates and Facilities	Exemption	Exempt - Rental Payment
Rumney Medical Centre Rent 2025 (PHP Primary Properties)	£72,492.00	One-off Requirement	Capital Planning Estates and Facilities	Exemption	Exempt - Rental Payment
Rent and Rates and Service Charge of Unit 1 (Fisher German)	£43,926.87	29/09/2025 to 24/12/20025	Clinical Diagnostics & Therapies	Exemption	Exempt - Rental Payment
Project Name 2026 Surveillance 2	£13,117.75	2026	Clinical Diagnostics & Therapies	UKAS Accreditation – Mandatory Requirement	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
WEQAS Payment of invoice 202500009280 & 202500009284, Unit 1 & 6 - Insurance 2025 - 2026	£5,228.68	2025/2026	Clinical Diagnostics & Therapies	Exemption	Exempt - Rental Payment

It should be noted that Procurement 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 surplus budget position, Clinical Boards will be reminded of their obligation to engage with Procurement 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 (1) requests during the period from the 1st August 2025 to 31st October 2025.

It should also be noted that, 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
Children & Women	Swansea University	PHD Opportunity to improve Paediatric Healthcare	£55,000.00	Partnership Arrangements

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.

Clinical Board	2023/24 (FY)		2024/25 (FY)		2025/26(YTD)	
	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption
AWMGS	1	0	14	0	5	1
Children and Women	3	0	11	0	4	3
Capital Planning, Estates and Facilities	2	3	17	7	17	14
Clinical, Diagnostics and Therapies	11	4	27	4	22	8
Executives	21	9	35	20	8	1
Medicine	1	0	3	0	1	0
Mental Health	2	1	10	0	3	4
PCIC	2	0	11	0	4	5
Specialist	10	1	11	2	6	1
Surgery and Dental	10	0	8	1	2	0
TOTALS	63	18	147	34	72	36

STA/SQA's by Department

Clinical Board	2023/24 (FY)		2024/25 (FY)		2025/26(YTD)	
	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	1	0
Medicine	0	0	3	0	0	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	12	0

Summary of the Key Issues

It is recognised that there are issues that need to be addressed as follows:

1. **High Levels of Non-Compliant Spend** - there are significant fluctuations in monthly spend with peaks driven by exemptions and emergency repairs and retrospective payments. In CEF/Execs there are PFI service charges and rental, and in CD&T, emergency repairs/retrospective payments and in both areas, April and August are consistently high months.
2. **Root Causes of Non-Compliance** – (i) lack of early engagement with Procurement by Clinical Boards with limited awareness of SFI's in some areas; (ii) Poor contract lifecycle management; (iii) Absence of pre-approval mechanisms for urgent works.
3. **Governance Weaknesses** – retrospective approvals and advisory actions dominate which are linked to the limited awareness of SFI's, resulting in being reactive to governance controls as opposed to being proactive.
4. **Training and Awareness Gaps** – whilst training is ongoing, Procurement to refine its measurable KPI's to track progress, determine whether the training is being successful and identify areas for improvement where performance is lagging.
5. **Supplier Concentration Risk** – there are a small number of suppliers who account for a large proportion of spend, for example, IMC St. David's Ltd. (CEF&Execs) and GE/Diagnexia (CD&T). As stated above, the IMC St. David's expenditure relates to PFI service charges which would have been approved prior to the commencement of the PFI Scheme.
6. **Digital Governance Tools** – Procurement Services utilise the QlikSense and Adviselnc digital platforms however they are not fully integrated however, plans exist to enhance the real-time monitoring and automated alerts to improve the monitoring model.

Proposed/Recommended Actions

In recognition of the issues, it is proposed to undertake the following:

- Implement rapid response frameworks for emergency requirements. This will involve engagement with, and buy-in from, stakeholders to provide a realistic assessment of their requirements.
- Mandate early engagement protocols for all directorates, where early interaction with relevant parties are initiated. This will help all participants to make informed decisions, facilitate cooperation and manage risk.
- Track training effectiveness using KPI's, such as pre and post training assessments to measure the impact, i.e. demonstrable reduction in non-compliance numbers.
- Document all exemptions which will provide clear audit-ready justifications in readiness for the Audit. This negates the inclusion of exempted areas that cannot be influenced by Procurement.
- Strengthen contract monitoring and include this activity as part of the Procurement daily workplan reviews and application of the RAG ratings.
- Integrate digital tools into a unified governance dashboard to streamline the monitoring process.

The above actions will take time to develop and introduce and may not make a substantial impact over the approaching months, however, once they have been established and embedded across all directorates, they will deliver positive future audit outcomes.





Recommendation:

The Board / 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
 Delivering in the Right Places	 Acting for the Future

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

Pr ev ent ion		Long term		Integration		Collaboration		Involvement	
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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:

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Procurement Services Update – Key Actions

Claire Salisbury

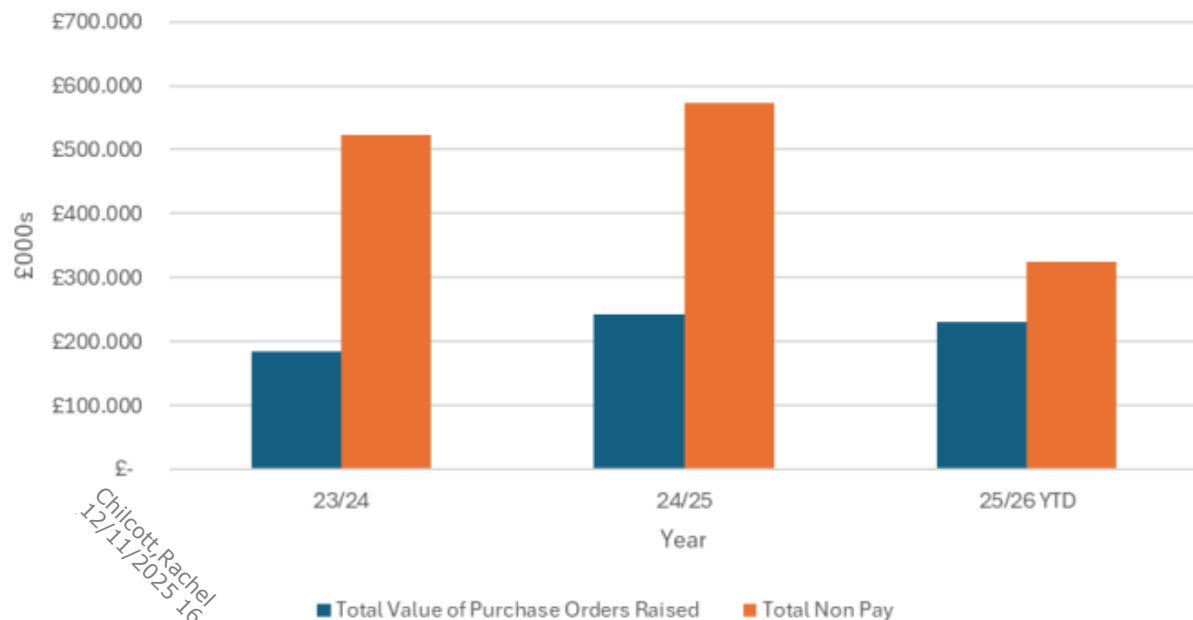
Deputy Director, NWSSP Procurement Services

Executive Procurement Lead CVU HB

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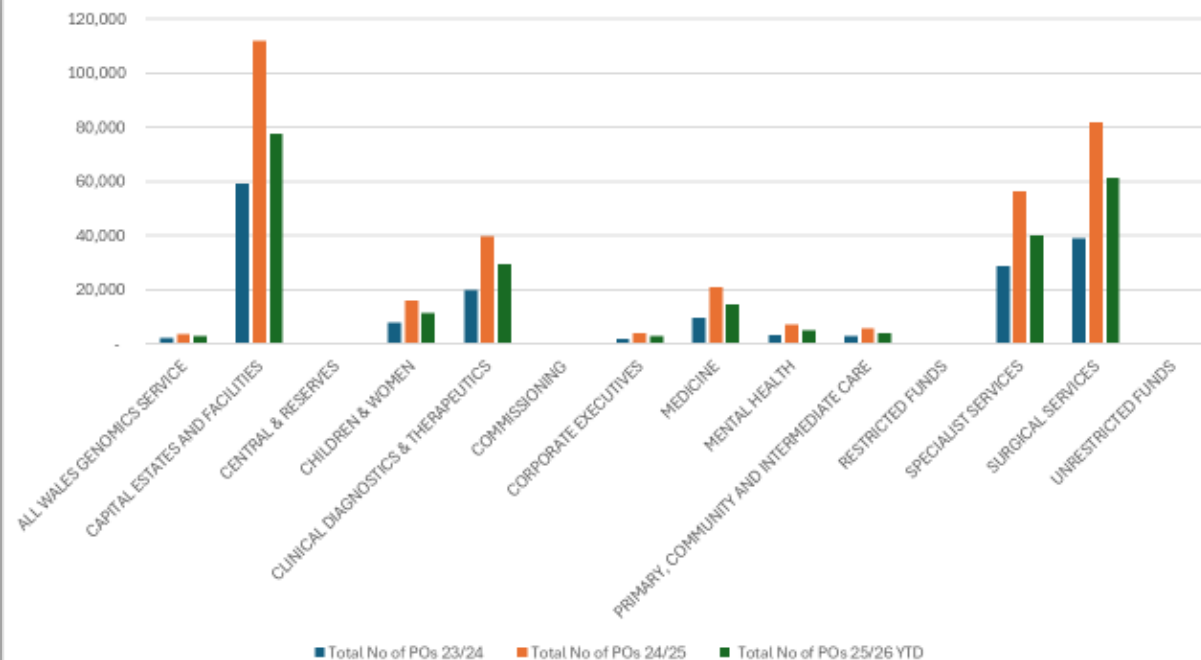
Purchase Orders

Total Purchase Orders Raised

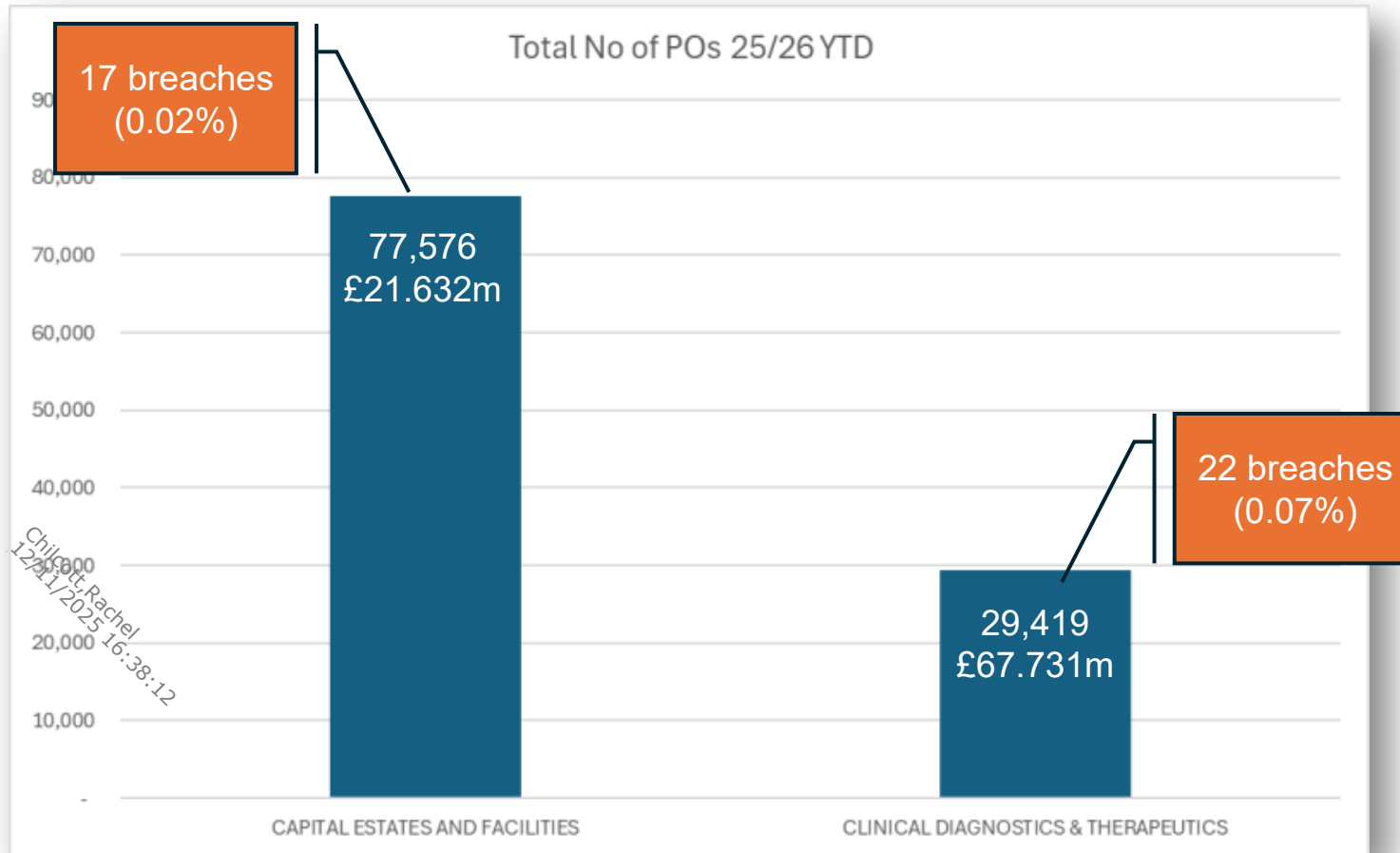


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Total Number of Purchase Orders by Clinical Board



Spotlight on Recurring Non-Compliant Areas



All Clinical Boards



**Total POs raised
25/26 YTD**

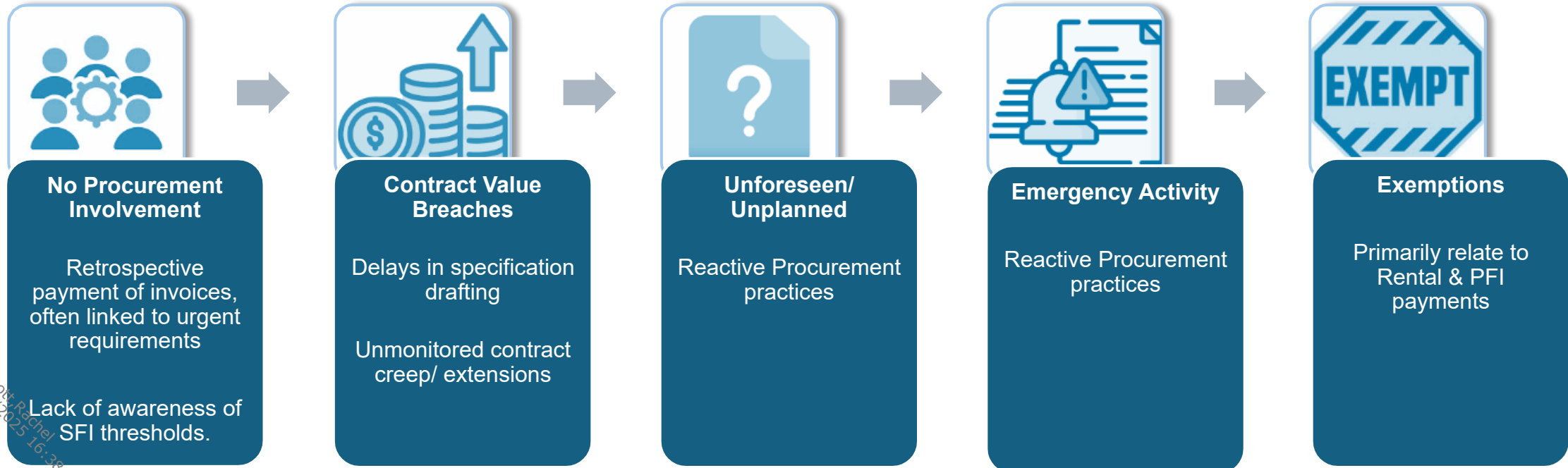
248,666 (£230.341m)



**Total Non-Compliant
Breaches**

72 (0.03%)

Reportable Activity



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Training delivered on Procurement Regulations and Standing Financial Instructions

	Surgery	CD&T	CEF	Medical Genetics	Specialist	PCIC & MH	C&W	Medicine	Executives
Training Delivered	14/01/2025 24/04/2025 12/06/2025 16/06/2025 19/06/2025 11/09/2025 14/10/2025	17/09/2025 14/10/2025 Fortnightly calls set up	17/04/2025 14/07/2025 25/07/2025 20/08/2025 22/09/2025 02/10/2025	02/06/2025 27/08/2025	06/06/2025 24/06/2025 11/08/2025 14/08/2025	30/06/2025 10/07/2025 21-23/07/2025 28/07/2025 20/08/2025 29/08/2025 04/09/2025 11/09/2025	05/06/2025 23/10/2025	19/08/2025 10/10/2025 27/10/2025	24/06/2025 07/07/2025 02/07/2025 24/09/2025 03/10/2025

Procurement Compliance Training Summary

- **Targeted Engagement:** Sessions emphasised the importance of procurement compliance and governance, particularly around spend thresholds and contract management.
- **Hands-On Support:** Daily interactions with end users, reinforced key compliance messages. Non-compliant requisitions were addressed promptly with clear corrective guidance.
- **Policy Advice:** End users were advised on HB/Procurement Standing Financial Instructions (SFIs), including the requirement for contractual agreements on spend over £5,000.
- **Regulatory Changes :-** New Procurement Legislation changes (Procurement Act 2023), and Provider Selection Regime (PSR)

Mitigation Approach

Transactional Compliant Routes:

3 quote exercises

Direct award via frameworks

Transparency notices

Variation to current agreement (CCN)

Subcontracting to existing suppliers on contract

Exempt award of contracts (public bodies only)



Proactive Approach:

Strengthen governance and internal control (policies, SOPs, DOIs..etc)

Improve Planning and Early Engagement (forecast needs, budget cycles, project planning, teams channels for communication...etc)

Enhance transparency and Audit Readiness (decision logs, approvals, communication, waiver and STA tracking...etc)

Monitor and report risks proactively (risk registers, mitigate potential breach...etc)

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GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Caffael
Shared Services
Partnership
Procurement Services

Driving Improvements



Mandatory/Ad hoc Training Sessions

Delivered to all directorates, focusing on key areas such as Standing Financial Instructions (SFIs) thresholds, emergency procurement processes, and contract management.



Audit

Exemptions are documented with clear justification to provide full transparency for audit purposes



Promoting the use of Pre-Approved Supplier Lists

Under Contract & Framework agreements, categories such as estates maintenance, labour, and waste management. This approach provides assurance that reactive procurement remains compliant and auditable, reducing risk for both operational teams and the organisation.



KPIs to track effectiveness

Reductions in breaches, improved engagement

Report Title:	Procurement Compliance Report – Chair’s Action Review			Agenda Item no.	2.5
Meeting:	Audit Committee	Public	X	Meeting Date:	18 th November 2025
		Private			
Status <i>(please tick one only):</i>	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:

The UHB’s Standing Orders & Standing Financial Instructions require that Board approval is obtained for the purchase of all goods and services for contracts over the value of £1,000,000.

There are some situations where approval must be sought outside Board approval and therefore, a Chair’s Action request is submitted. The reasons can be as follows;-

- Urgent Operational Requirement
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

A review of the number of Board and Chair’s Actions reports was requested by the Director of Finance and following the initial report in March 2022, an annual report is now provided by Procurement Services.

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

In March 2022, a review of Board approvals was undertaken for financial year 2021/22 and up to December 2022 for 2022/23 financial year. In 2021/22 the majority of approvals (72) were issued via the Chair’s Action route with 2 through the formal Board meeting. During the financial year 2022/23 up to December 2022 (at the time of the first report), Procurement Services issued 36 requests. This was highlighted to Procurement Services and therefore, planning for approval was advised to be in line with Board meeting dates.

In order to confirm the number of genuine Chair’s Action requests, Procurement commenced tracking the Board/Chair’s Action requests from September 2022 with the below categories. In addition to these categories, two further types (categories 6 and 7) were included in January 2023;

1. Board Agenda does not have capacity for request
2. Emergency/Unforeseen circumstances
3. Exemption - contract value above estimated contract value
4. Procurement have not provided sufficient time within Board dates for approval.
5. Urgent Operational Requirement
6. Delays to process causing Procurement Services to miss the project planned Board date
7. AW Contracts Ratification which are being challenged and/or not in line with Board dates

It should be noted that in January 2024, the Board approved a request from Executives to amend the delegated financial limits in line with other Health Boards in Wales, details as follows;

Table 1 Delegated Financial Thresholds and Approvers

Delegation	Delegated Financial limit Prior to January 2024 £’000	Delegated Financial limit From to January 2024 £’000
Reserved for Board	>500	>1,000
Chief Executive	500	1,000
Director of Finance	125	500

Please note that WG reporting /approving requirements remain.

Table 2 below provides the numbers and categories for the Chair's Actions from the initial report through to the 30th September 2025 in financial years.

Table 2 – Category and Numbers of Board and Chair Actions Requests

Cat No.	Category	2022/23	2023/24	2024/25	2025/26 (YTD)
1	Board Agenda does not have capacity for request	7	4	0	0
2	Emergency/Unforeseen circumstances	3	1	1	0
3	Exemption - contract value above estimated contract value	0	0	1	0
4	Procurement have not provided sufficient time within Board dates for approval	2	1	0	0
5	Urgent Operational Requirement	26	4	11	3
6	Delays to process causing Procurement to miss the project planned Board date	6	5	1	0
7	AW Contracts Ratification which are being challenged and/or not in line with Board dates	1	4	0	0
Total		45	19	14	3

It is noted that there has been a significant improvement, attributed to enhanced planning and the changes in the delegated financial limits.





Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	Long term	Integration	Collaboration	Involvement
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Impact Assessment:

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

Risk:

As outlined in the above section

Safety:

As outlined in the above section	
Financial:	
As outlined in the above section	
Workforce:	
As outlined in the above section	
Legal:	
As outlined in the above section	
Reputational:	
As outlined in the above section	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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12/11/2025 16:38:12

Report Title:	Audit Tracker Update Report		Agenda Item no.	2.6
Meeting:	Audit and Assurance Committee	Public	X	Meeting Date: 18.11.2025
		Private		
Status:	Assurance	X	Approval	Information
Lead Executive:	Director of Corporate Governance			
Report Author:	Corporate Governance Officer			

Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee with assurance on the progress of actions which have been made by Internal Audit and Audit Wales. This report also provides the outcome of a review of the regulatory audit tracking process.

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

Internal Audit Tracker Update

Internal Audit monitoring

Monthly meetings between Internal Audit and Corporate Governance are now established to review internal audits. These sessions provide a collaborative platform to track audit progress, address team queries and consider requests to revise action deadlines or explain why certain actions cannot be completed and agree the best course of action.

Current Internal Audit Tracker Statistics

Since the previous time the internal audit trackers were presented in May 2025, 9 additional Internal Audit reports have been issued.

As of the 11th November 2025, there are 150 actions:

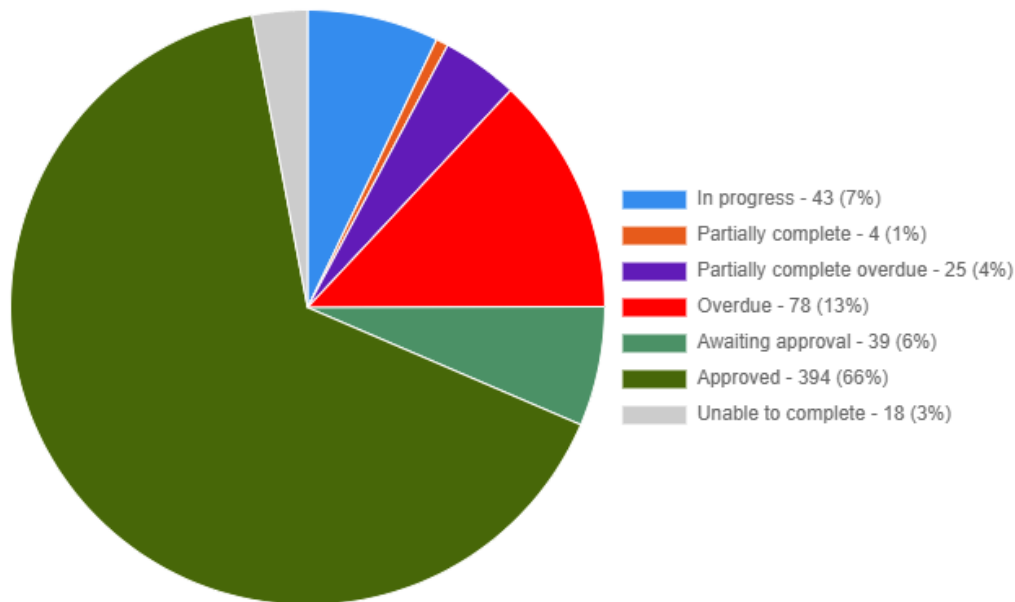
- 46 are High Priority
- 70 are Medium Priority
- 34 are Low Priority

Of the 150 actions, 103 (68.7%) are overdue.

Work to progress the oldest outstanding internal audit actions remain ongoing, and work is progressing well. In September Audit Committee, there were 4 overdue actions from 2023 of 2 have been closed. In addition, 56 open actions were identified from 2024 in the previous Committee. There are now only 24 open actions from 2024, demonstrating a 57.14% reduction in the reporting period. The reduction in actions is mainly due to teams actively reviewing their oldest open actions, with a minor contribution from action extension requests being approved with audit.

The image below displays the current data extracted from AMAT detailing the status of the actions.

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12/11/2025 16:38:12*



Appendix 1 provides a list of all closed/completed actions since the previous Audit Committee in May 2025 for the Committee’s information.

Action extension requests & Actions unable to complete

The table below contains a summary of the actions with revised deadline dates for the Committee’s oversight with an explanation of why an extension has been requested.

Audit Title	Date from	Date to	Comments
LIMITED - Decarbonisation	Sep / Dec 2024	Dec-25	All actions extended due to changes within the team and this is when the new Climate Response Plan will be in place. This has been agreed with Internal Audit.
Community Patient Appliances (Specialist Services CB)	Sep-25	Mar-26	One action extended due to recruitment being in progress, and it would allow time for the new staff to be in post, have had training, and hopefully the team will be up to speed to be able to address the concerns within the action.

Appendix 2 contains a list of the actions marked as ‘unable to complete’ since May 2025 with reasons behind this progress position.

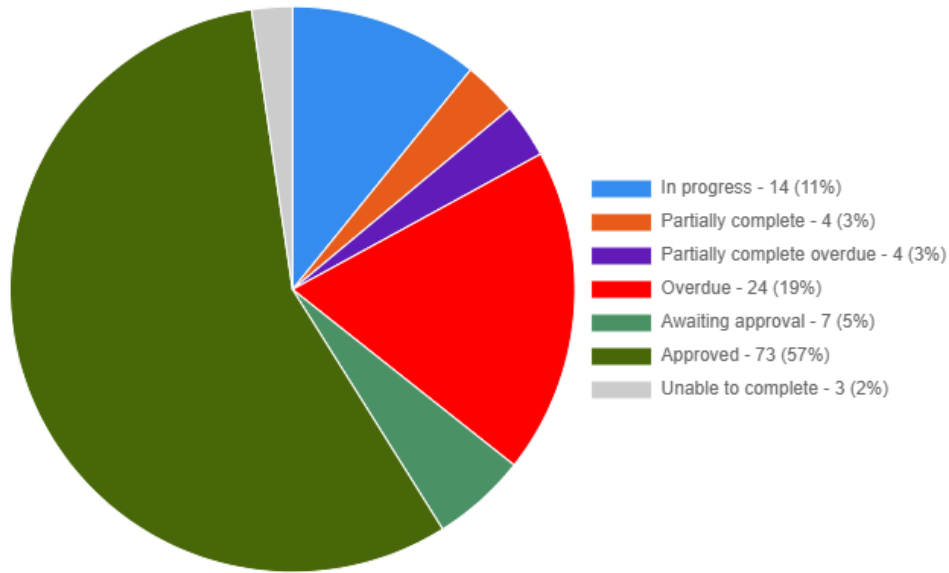
Audit Wales Tracker Update

All Audit Wales recommendations and actions since 2022 have been migrated onto AMAT and the same process for managing the Audit Wales tracker applies as Internal Audit.

Monthly meetings between Audit Wales and Corporate Governance are now established to review Audit Wales audits. These sessions provide a collaborative platform to track audit progress, address team queries and consider requests to revise action deadlines or explain why certain actions cannot be completed and agree the best course of action.

Current Audit Wales Tracker Statistics:

The image below displays the current data extracted from AMAT detailing the status of the actions.



As at 11th November 2025, there are 46 actions:

- 19 are High Priority
- 27 are Medium Priority

Of these 46 actions, 28 or 60.9% of these are overdue.

At present, the oldest actions for Audit Wales date to May 2024. Targeted work is underway with action leads to review and update these actions on AMAT.

- 2 actions from 2024
- 26 actions from 2025

Comparison data will be available and shared at the February 2026 Audit Committee to demonstrate the progress made during the reporting period.

Appendix 3 contains a summary of the actions with revised deadline dates for the Committee's oversight with an explanation of why an extension has been requested.

The table below contains a summary of the actions marked as 'Unable to Complete' for the Committee's oversight with an explanation of why this is the outcome.

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Audit Title	Recommendation	Action	Status Reason
Review of Workforce Planning Arrangements	Managing risk - The scale of the Health Board's workforce challenges means that the actions it is taking are having limited effect on reducing workforce risks. The Clinical Board's high-level clinical plans and workforce baseline plans have the potential to highlight new workforce risks. The Health Board should review the information in its corporate and strategic risk registers, using fresh insight from the high-level clinical plans and workforce baseline plans, to identify potential additional sources of assurance and new risks (high priority).	Clinical Board plans will be reviewed as part of the Annual Planning cycle and any new workforce risks will be escalated to Board via the BAF and Risk Registers. Appropriate plans will then be developed to mitigate the risks.	We are unable to complete this at the current time because without a clinical services plan we can't develop a workforce plan, but that when we do develop one risks will be considered. Risks have recently been escalated to Management Exec regarding Nurse and Non-nursing graduate recruitment risks and that further workforce risks will be identified and reported as part of the Education Commissioning process and submission for 26/27 and on an ongoing basis going forward.
Review of Quality Governance Arrangements	Resources to support quality governance - Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.	1. The increase in concerns remains significant and resource is an issue. There has been some investment through the Business case which spans a three-year period.	The increase in complaints activity is sustained and from April 1 2026 the new Listening to People regulations will initially increase demand and require different ways of working within existing structures. There was some investment over 2 years but the concerns team remains very fragile and dependent upon redeployed staff. We are preparing for the revised PTR regulations which will require a different model. We have established an enquiries line to try and reduce enquiry type concerns and deal with promptly any questions at the earliest opportunity
Estates Follow-up Review	Develop a fully-costed Estates Management Strategy - The Health Board could not provide a copy of its estate management strategy which it reported was agreed in 2017. However, the Health Board is currently in the early stages of developing a new estates strategy. The new strategy should clearly set out: <ul style="list-style-type: none"> a baseline assessment of the condition of the current estate and the total resources (including workforce) needed to maintain it against available resources; how the estate will be maintained and resourced to the required standard in the short- and medium term; and plans for maintaining and investing in the current estate whilst implementing its estates investment programme. 	<ul style="list-style-type: none"> A copy of the estate's strategy based on the operational team requirements was provided, but this strategy dealt with service delivery and did not review, in depth, the outlined areas contained within this audit recommendation. The Estates Strategy going forward will provide the following as outlined within the recommendation. In the interim and immediate; it will state how the estate will be maintained, based on current workforce and funding, until the baseline assessment has been completed. The strategy will outline, where necessary, the prioritisation of work in relation to patient safety, health and safety, structural integrity and statutory compliance against the backdrop of available budgets and workforce. It will indicate that a baseline assessment will be completed and programme of completion provided. The baseline assessment will include a condition survey review in accordance with Estate code, six facet survey or similar. This survey information will then be used to assess, prioritise and re-align the workforce, required to maintain the site, dependent on the highlighted risks within the survey, and the available budget within the Health Board, in the short- and medium-term. It is anticipated that the survey information will take approximately 18 months to procure and complete. A further period of implementation will be essential if workforce changes are required as a result of the outcome. This detail will be provided within the Estate Strategy, provided within the Estate Strategy. 	Awaiting final documentation

Appendix 4 contains a summary of all outstanding Audit Wales actions as at 11th November 2025.

Regulatory Audit Tracker Update

What Is Regulatory Auditing at Cardiff and Vale UHB?

Regulatory auditing refers to formal inspections or reviews conducted to ensure compliance with statutory, legal, or regulatory requirements. These are often external and mandated by bodies such as the Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW) and the Information Commissioners Office (ICO) etc.

The Corporate Governance team has been undertaking a review across the UHB to understand how teams manage their regulatory auditing locally with a focus on how regulatory inspections and reports are received, monitored, tracked and reported. This work consists of fact-finding engagement sessions with teams to review process.

Attachment 5 provides a high-level overview of the regulatory audit review undertaken across the organisation by Corporate Governance.

The findings of the review have found the following key points:

- Assurance is given to Committee that Regulatory Inspections happen across the UHB and the correct teams are engaged with the appropriate regulatory/statutory body to support the process
- Inconsistencies in managing the process- most regulatory inspections and findings are managed locally within teams via local spreadsheets and processes, and some teams utilising the AMAT (Audit Management and Tracking) digital platform to manage these audits
- Regulatory Inspections are escalated; however, gaps have been identified to ensure the escalation routes are appropriate
- Assurance of the process is limited in many areas of regulatory inspections

The following actions have been identified to streamline the process for regulatory audit inspection tracking:

- Work with teams to explore shifting the process of managing inspections onto AMAT to allow for greater functionality and visibility of regulatory audit tracking at a corporate level. This streamlines all audit tracking management to the same digital platform (AMAT) providing consistency and stronger governance arrangements.
- Where AMAT is not the default platform for managing regulatory inspections, request teams provide assurance to Audit Committee to evidence the process for managing their regulatory inspections
- Strengthen and challenge the escalation and governance route for regulatory inspections

Next Steps

- AMAT System functionality - discussions are ongoing with the AMAT team to enhance the user friendliness of the system to manage audit trackers. AMAT system updates are due in Q4 2025/26 based on requests made by CAVUHB and other Health Boards who are all working towards enhancing the system for managing audit tracking across Wales.
- Tri-Annual Audit Trackers will be shared at Audit Committee by exception, with the next update scheduled for February 2026.
- Corporate Governance to progress with the actions identified to streamline the process for regulatory audit inspections
- Corporate Governance to develop a guide to outline the process for all Audit Tracking





Recommendation:

The Committee is requested to:

- a) Note and receive assurance on the progress made for Internal Audit & Audit Wales audit actions to date;
- b) Note and be assured by the progress undertaken to review the regulatory audit tracking process and support the actions identified to streamline the process for regulatory audit inspection tracking

Link to Strategic Objectives of Shaping our Future Wellbeing:

<https://shapingourfuturewellbeing.com/>

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

Five Ways of Working (Sustainable Development Principles) considered

Pr ev		Lo ng	Integration	Collaboration		Involve ment	
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en tio n		ter m						
Quality Impact Assessment Completed?								
Yes – <i>(please provide completed QIA document)</i>		No – <i>(Please provide reasoning, e.g. not required)</i>			X	n/a		
Impact Assessment:								
Risk: Yes/No								
<i>By maintaining an up to date Internal Audit Recommendation Tracker the Health Board mitigates the risk that it may be subject to legal or regulatory penalty.</i>								
Safety: n/a								
Financial: n/a								
Workforce: n/a								
Legal: n/a								
Reputational: n/a								
Socio Economic: n/a								
Equality and Health: n/a								
Decarbonisation: n/a								
Welsh Language: n/a								
Approval/Scrutiny Route <i>(please note anywhere else this paper has been before):</i>								
Committee/Group/Exec		Date:						

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Inspection Title	Recommendation	Action	Responsible Person	Due Date	Date Last Updated	Action Rating	Risks	Barriers	Comments/Updates	Evidence
Implementation of National IT Systems (WNCR)	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue. The process established includes: <ul style="list-style-type: none"> Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work; Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; Informal executive to executive meetings planned for every 3 months. 	Russell Kent	30/06/2025	11/11/2025	Amber			<p>July 2024 IA tracker update: June 2024 - WNCR continues to progress from a Digital point of view with the deployment of the first 50 iPads and testing. The rest of the devices are scheduled to be deployed subject to approval of testing in Q2/3 2024.</p> <p>March 2025 - WNCR roll out anticipated to complete in June 2025. CAV requirements relating to WNCR programme are managed through national service management board.</p> <p>Oct 2025: The last update references Digital Director three monthly updates on progression. I do not attend these meeting and have not been involved in any of these conversations or arrangements. This task can either be closed or should be transferred to David Thomas as ongoing.</p> <p>Nov 2025 - Director of Digital & Health Intelligence has confirmed that this action can be closed.</p>	20251111155453_fwconfirmationofactionfrom2022internalauditimplementationofnationalitysystemswnocr.msg
Waiting List Management	RTT/Waiting List Validation training - The Health Board has developed a wide range of quick reference guides and e-learning modules to support staffs understanding of Referral to Treatment (RTT) rules. However, there is no consistent or formal mechanism in place to assess, record, or evaluate staff comprehension and application of these rules in practice and of the steps to be followed during the validation of waiting lists. This gap mirrors a similar issue identified at Swansea Bay UHB, where training was delivered but staff lacked foundational knowledge, impacting data quality and pathway management.	The Health Board will implement a formal and consistent process to assess and record staffs understanding of RTT rules following training. This will include mandatory assessments, periodic refresher evaluations, and integration of results into performance reviews. Doing so will provide assurance that staff are equipped to apply RTT and waiting list validation principles accurately and consistently.	Ms Rachel Chilcott	05/08/2025	05/08/2025	Amber			<p>August 2025 - the Internal Audit final report noted that the action has already been completed.</p>	
Follow-up: Temporary Staffing Costs	A consistent approach to roster management should be implemented within Capital, Estates and Facilities to ensure compliance with the Health Board wide Rostering Procedures. Medium Agreed Management Action Target.	The E-Rostering team are working closely with Heads of Service within CEF to prepare the service for the implementation of HealthRoster. However, it is recognised that there is significant work in rolling out the roster within CEF due to the differing shift patterns that are present across the services and within the individual services. This will require a significant time commitment from the services within CEF and therefore cost, whilst still trying to deliver operational services. CEF is committed to complete the implementation within the next 6 months.	Paul Jones	31/12/2024	16/10/2025	Amber			<p>October 2025 IA report findings - The E-rostering team have completed the migration of Capital, Estates and Facilities areas to Health Roster including Housekeeping teams. Roster reviews are currently underway with regular monthly meetings scheduled to ensure the areas are fully utilising the system and regular reports are provided. Conclusion: The recommendation is complete.</p> <p>May 2025 IA report findings - The E-rostering team has successfully migrated Capital, Estates and Facilities teams to Health Roster with the exception of the housekeeping team which is due to move over by end of April 2025. Conclusion: The recommendation is partially complete. However, we have not raised a new recommendation as the move onto Health Roster by housekeeping is already planned.</p>	

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PCIC Governance Arrangements	<p>All TOR for the groups within the PCIC Clinical Board should be reviewed to assess whether they are up to date, updated where necessary and then formally approved.</p> <p>As part of the review, consideration should be given to whether attendees are core or optional and this should be clearly stated.</p>	<p>All Terms of Reference to be reviewed, updated and formally approved highest priority to be given to:</p> <ul style="list-style-type: none"> • PCIC SMT • PCIC QS&E • PCIC Clinical Board • PCIC Local Partnership Forum • Current Clinical Services Reference Group • Primary Care Panel <p>Consideration to be given to timescale for reinstatement of PCIC IG Group and review and formal approval of Terms of Reference.</p>	Ms Anna Mogie	30/09/2024	28/07/2025	Green	<p>ToR for all key groups referenced in action plan have been reviewed and signed off. Consideration still being given to re-establishment of PCIC IG Group</p> <p>20241015102807_04minutes17sep2024.docx</p>
Mortuary Refurbishment at University Hospital Wales	<p>The review of the Capital Projects Manual should be concluded and approved as soon as possible, and brought into use for all projects delivered by Capital, Estates & Facilities as previously agreed.</p>	<p>Agreed. A revised Capital Planning Manual in draft has been developed and is being reviewed internally. Upon completion of internal review, it will be shared with colleagues in NWSSP A&A SSu to comment and advise on any suggested amendments etc. The document will then be updated as necessary prior to it being considered within the UHB governance framework for approval, with the intention to implement from 1st June 2025.</p>	Mr Gavin Evans	31/05/2025	07/11/2025	Amber	<p>Due to workload and staffing issues with the change in Head of Department the review of the draft manual has been delayed. Internal review will now be completed by the end of 2025.</p>
Capital Systems 2023/24	<p>Project officers should ensure that returned contracts and Chair's action are signed, initialled, and dated consistently.</p>	<p>Guidance will be issued across the Project Management and Executive cohort to remind approvers of the importance of clearly dating formal documents when signing.</p>	Nigel Mason	31/10/2023	07/11/2025	Amber	<p>Guidance has been issued to Project Manager to check contracts are dated, documents are processed via docusign before orders are raised with senior management authorisation.</p>
LIMITED - Estates Condition	<p>1.1 - The lead executive should approve the proposed approach to the surveys, recognising any benefits/limitations of the approach taken</p> <p>1.2 Surveys should be carried out on the UHB estate with the results informing both an updated estates strategy and EFPMS returns</p>	<p>Agreed - Condition surveys were tendered in November 2023. The tenders received did not provide a competitive response. Therefore, the tender is being re-issued in Jan 2024. It is anticipated that the surveys and completion of the reports will not be achieved until July 2025. EFPMS will continue to be updated, until after the condition survey update, using informed data.</p>	Mr Gavin Evans	29/02/2024	07/11/2025	Amber	<p>Dec 2024 - Funding has been approved for the commencement of the Business Case Enabling Works to provide information on the UHB Buildings to support and inform future Business Case developments. The surveys are due to commence in January 2025.</p>
LIMITED Alcohol Standards	<p>1.1 - Health Board should compile guidance which aligns to the NICE recommendations on detailing the screening process, the brief interventions that will be followed, and who should be targeted and action that should be taken.</p> <p>2.2 - the fact that alcohol related harm is a major health problem, internal reporting within the Health Board should be undertaken to ensure that Senior Managers are aware of the number of patients who are presenting with alcohol issues.</p>	<p>Funding for fixed term post (to March 2025) for Alcohol Programme Manager secured to support the implementation of management actions:</p> <p>1.1 - Guidance for the screening process, the brief interventions to be followed and</p> <p>2.2 - who should be targeted will be produced and disseminated to relevant staff.</p> <p>The collation of data from the screening process will be standardised and reported quarterly to the appropriate Senior Managers.</p>	Lauren Idowu	30/06/2024	12/06/2025	Red	<p>June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report.</p> <p>July 2024 IA tracker update: 1. WG funding secured for Alcohol Programme Manager post. Preparing for recruitment of post.</p>

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LIMITED - Interventions Not Normally Undertaken (INNU)	<p>1.1 - A complete set of Hospital Health Pathways should be developed and added to the Hospital Health Pathways Portal to aid consistent application of the INNU policy.</p> <p>1.2 - Following completion of the Health Technology Wales Review, the Health Board should incorporate the Welsh Government (WG) INNU guidance dated 25 August 2023 into its policy or engage with WG if clinicians have concerns.</p> <p>1.3 - Clinical codes (where available) should be put in place for all interventions to enable identification, categorisation and monitoring to be undertaken.</p>	<p>1.2 - The INNU Policy is due for revision Q2-2025 however activities commenced early (2023) to respond to the WG Guidance letter as referenced above. Clinical leads of each speciality area have been notified of the procedures within their respective areas listed in the Welsh Government (WG) issued 'INNU New National Approach' guidance. They have been requested to provide approval for the procedures to be included in the CAVUHB policy and to confirm the narrative attached to each procedure is appropriate. This activity is scheduled to be completed by end of Q4 24/25, however there is still a requirement for an evidence review to be completed from HTW prior to publishing.</p>	Mrs Sophia Jones	31/10/2025	31/10/2025	Amber	<p>Policy update approved in Quality Committee 28th October. Policy has a live intervention list with governance process approved by committee and corporate governance, to update when the evidence reviews have been completed by the National Group.</p>	<p>20251106094046_uhb009innupolicyv05.docx, 20251106094115_interventionsnotnormalyundertaken2025listofinterventions2.docx, 20251106094126_ehiainnupolicyrefreshv211.docx, 20251106094136_311aqualitycommittee281025innupolicyrefreshboardcommitteecoveringreport.docx, 20251106094145_311binnupolicyupdateoctober2025.pptx</p>
Cyber Security Follow up	<p>A realistic timetable should be developed, and accountable officer(s) assigned to progress the Cyber Security Improvement Plan.</p>	<p>We do recognise progress has been slower than we would like. It is widely reported over many years empirically that recruiting to cyber roles is highly competitive with the public sector often struggling for capable resources as pay points are lower, hence we have spent 12 months running numerous unsuccessful recruitment campaigns including the use of agency to no avail. Our most recent campaign however was successful after we increased the pay scale for an appointee to Band 8a (from Band 7).</p> <p>The Cyber Security Lead is due to commence in post on the 14th May 2024. The improvement plan was largely written in the context of the critical system assessed in 2022 (PMS). PMS is currently migrating to a new environment and once migrated, currently scheduled for April 2024, a number of recommendations will be addressed. This, in addition to the Cyber Security Lead position being filled, will allow us to make some good headway into this action plan.</p>	Mr James Webb	30/06/2024	06/08/2025	Green	<p>August 2025- Cyber security lead in post. action to be closed as added retrospectively.</p>	
Management of Health Board Policies Follow-Up	<p>1.1 - The draft changes to 'UHB 242 - Written Control Documents - Development and Approval Procedure' which have been prepared to reflect the new arrangements and incorporate the Standing Operating Procedure should be formally reviewed, approved and communicated to relevant personnel.</p> <p>1.2- The Health Board's website and SharePoint should be reviewed to ensure that they have been appropriately updated, including all links, so that all relevant information is readily and easily available.</p>	<p>All policies across the 3 digital repository of SharePoint, Website and AMaT will continue to be streamlined and brought inline and synchronised with one another, this includes renaming all available PDFs online to include UHB Policy numbers to increase transparency and ease of access</p>	Mr Andrew Partridge	31/10/2024	21/10/2025	Amber		

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Financial Management within Clinical Boards	<p>The Clinical Board Finance Teams should review the 'reports database' to ensure that all budget holders details are up to date and take appropriate action to remove those staff that are no longer budget holders and if applicable add the details of any budget holders that are missing.</p> <p>Consideration should also be given that the Financial Systems Team issue the report to each Clinical Board Finance Team on a quarterly basis for review.</p>	<p>The Reports database is not the only platform for availability and review of financial information and support teams follow up with primary budget holders in monthly (or more often) meetings. Finance support teams will review their distribution at the same time as they liaise with budget holders on information needs to ensure that distribution lists are appropriate and up to date.</p>	robert mahoney	30/09/2024	20/10/2025	Amber	Business Partnering Teams have reviewed their report distribution.
Implementation of National IT Systems (WNCR)	All digital projects should be subject to a formal governance structure.	A formal project governance structure has been put in place including risk monitoring for the whole of the programme including digital. Formal monitoring will be provided via the WNCR Board meetings and any digital risks arising will be reported upwards to exec director level and, if necessary, to the Senior Leadership Board (formerly HSMB). Regular updates will also be submitted to the Digital & Health Intelligence committee.	Mr Aron White	31/10/2022	20/08/2025	Amber	<p>July 2024 IA tracker update:</p> <p>June 2024 - Audit completed by external supplier. Report submitted to network team to indicate extent of WiFi coverage. For network team to progress this work.</p> <p>Jan 2025 - ToR of programme board and governance structure previously shared as part of external audit. Updates provided to Nursing and Midwifery Board. WNCR programme progress also monitored by digital PMO and updates to digital advisory board</p>
Cyber Security Follow up	Key cyber security figures relating to server patching and perimeter controls should be consistently recorded, upon which performance measures and indicators can be developed and regularly reported to the Digital Health and Intelligence Committee.	<p>There have been numerous attempts made to reflect key performance indicators into the Cyber Security Digital Health and Intelligence Committee report. Standard performance indicators are difficult to measure and whilst we have consistently reported legacy Operating System figures, this doesn't truly represent our cyber security position.</p> <p>This will improve as we complete Performance Measures and Metrics.</p> <p>The February 2024 committee paper did report on a number of cyber metrics but this was more for awareness than a representation of performance. We can ensure we continue to report on legacy server OS and include metrics/indicators for other measures for future committees.</p>	Ms Rachel Chilcott	31/05/2024	06/08/2025	Amber	
Management of Health Board Policies Follow-Up	Work should continue to be undertaken to get all Health Board policies up to date as soon as possible.	Review of all policies will continue; all policies are now on AMaT and regular email notifications for over due items are being triggered these will continue to be monitored and chased for updates	Mr Andrew Partridge	31/01/2025	21/10/2025	Amber	<p>All policies are on AMaT. Regular automated emails are being sent. Corporate Governance continue to monitor over due reviews as send targeted emails to chase updates. In addition a progress graph by 'Policy Lead' will now be shared at SLT to increase awareness of the percentage volume each lead has in date / over due. Monitoring and chasing will continue to reduce the over due (our of date) count.</p>

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Mortuary Refurbishment at University Hospital Wales	The Acute Infrastructure & Sustainability Capital Programme Board should demonstrate that sufficient scrutiny and oversight is afforded to the mortuary project, noting the significant time and cost risks currently faced.	As an ongoing live project, the Director of Capital, Estates and Facilities reports progress and highlights risk on a monthly basis to the Capital Management Group. This group is responsible for the financial delivery of a scheme and recommends increases or otherwise to the funding of projects. Due to the uplift required for this scheme, the report requesting additional funding was discussed in the UHB Capital Management Group, the Senior Leadership Board and Board, where the additional funding was finally endorsed. In addition, the Project Team status reports and minutes are included in the papers for the Acute Infrastructure Board and the progress, programme and costs reported accordingly along with any decisions/issues for escalation.	Mr Geoff Walsh	23/01/2025	28/08/2025	Amber	This action has been marked as complete within the 23.01.2025 internal report.
Capital Systems Management (Framework)	Framework Policy - There was no framework policy in place to explain, for example: - What to do in case of contractor failure/ withdrawal. - Extenuating circumstances, such as merging of two individual framework contractors. - Responsibility and accountability for the framework - To ensure ongoing governance is outlined e.g. regular credit checking of contractor and parent companies etc.	Partially Completed: The draft Capital Management Plan appropriately references use of the framework. The plan is currently being peer reviewed and will be finalised when approval can be tabled. Policy will be drawn up to outline framework usage protocol, including changes to the framework, and ownership.	Mr Geoff Walsh	30/04/2025	07/11/2025	Amber	Awaiting comments on final draft from Internal Audit.
LIMITED Alcohol Standards	The Health Board should introduce an appropriate alcohol screening tool, in order to provide a more consistent approach to noting patient information and assisting in identifying people who potentially have an alcohol-use disorder.	Consistent recording mechanism for the chosen screening tool implemented and rolled out to all relevant teams. E.g. Electronic workstation	Lauren Idowu	30/09/2024	12/06/2025	Red	June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report. July 2024 IA tracker update: 1. This action will be undertaken by the Alcohol Programme Manager post.
LIMITED - Estates Condition	The Estate strategy should be updated to reflect items including performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	Agreed in principle - The estates strategy has constantly been reviewed, with many aspects within the document updated to provide responses to previous Board queries and the Welsh Government requests. The condition survey findings will help inform the direction of investment in relation to backlog maintenance, space utilisation, functional suitability and investment strategies. This information, along with reviewing the IMTP of clinical departments and the strategic direction of the Board will help inform the Estates Strategy.	Mr Gavin Evans	31/03/2024	07/11/2025	Amber	Dec 2024 - Funding has been approved for the commencement of the Business Case Enabling Works to provide information on the UHB Buildings to support and inform future Business Case developments. The surveys are due to commence in January 2025. The completion of the 2024/25 IMTP will also help inform the prioritisation of capital investment within the UHB Estate.

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Inclusion and Equality	To ensure compliance with the organisation's objectives and legislative requirements, management should undertake a review of the responsibilities of the team members and the structures in place within the Health Board to support the team.	The People and Culture Directorate will commence a benchmarking exercise to assess the effectiveness of current capacity compared to other NHS organisations. This is not restricted to the Equity and Inclusion Team, but also looking at Welsh Language, and Education, Culture and OD. This is being looked at alongside the UHBs commitment to delivering the SEP, meeting its SocioEconomic Duties, and responding to WG direction, including the Anti-Racist Wales Action Plan; WRES etc. This will be completed, and the UHB will be presented with a paper, outlining the findings, team capacity findings highlighting any areas of risk / any short-falls. This will go to the People and Culture Committee in the first instance.	Mr Mitchell Jones	31/08/2025	23/10/2025	Red	<p>Legal Risks</p> <p>Non-Compliance with Equality Legislation: CVUHB risks non-compliance with the Equality Act 2010, which mandates public bodies to eliminate discrimination, advance equality of opportunity, and foster good relations between different people. Non-compliance can lead to legal challenges, fines, and reputational damage.</p> <p>Increased Discrimination Claims: could result in inadequate handling of discrimination complaints, leading to an increase in legal claims from employees or patients who feel they have been treated unfairly.</p> <p>Failure to Complete Equality Health Impact Assessments (EHIA): Not completing EHIA can result in policies and practices that inadvertently discriminate against certain groups. This can lead to legal challenges and undermine the trust and confidence of both staff and the community. It is also a legal requirement for us to undertake EHIA as part of our Public Sector Equality Duty under the Equality Act 2010.</p>	<p>May 2024 IA tracker update: The benchmarking exercise has been completed and a paper discussed with the Executive Director of P&C in the first instance. Current organisational demands have highlighted areas of risk around organisational development, culture, leadership, workforce planning and analytics. Work is currently underway to prioritise organisational to inform further investment. Business Case currently in development to be presented April 2024. The department recognises a limited resource within Equity & Inclusion; however, the current financial climate impacts on the ability to move forward with this. This will continue to be logged as a risk. with a view to revisit in 2024. The business case to be presented to the IG in October 2024.</p> <p>March 2025 IA tracker update: Business case still awaiting approval. Due to current organisational financial challenges, recruitment to the E&I team has been put on hold and will be revisited in April 2025.</p>
UHW Hybrid and Major Trauma Theatres	2.1 - The UHB should consider putting in place a dedicated Project Board for this scheme ahead of the Construction phase commencing to ensure appropriate oversight.	Agreed – Director of Capital, Estates & Facilities to initiate discussions with an aim to take forward within the UHB. This will not be finalised until Welsh Government approval of funding has been approved, therefore target date will need to be reviewed.	Mr Gavin Evans	31/10/2025	08/09/2025	Amber		<p>July 2024 IA tracker update: Business case still Agreed - A dedicated Project Board will be established following approval of the scheme by WG however the scheme is still currently being reviewed by CAV following comments received from WG.</p>
Implementation of National IT Systems (WNCR)	A project plan should be developed that shows the scheduling of wards, and the processes required to implement within wards, along with the timescales and resource requirements.	<p>There are two components to this recommendation:</p> <p>1. Development of an implementation schedule</p> <p>A provision roll-out schedule was devised in March 2022. This schedule indicated the data for implementation and equipment required on each ward. However, further WNCR implementation is unlikely to progress in the UHB until April 2023. This pause is necessitated to accommodate the launch of another digital platform Safecare. The UHB will also enter its ePMA implementation phase in April 2023.</p> <p>Actions:</p> <ul style="list-style-type: none"> - Revise the WNCR roll out schedule in response to the Safecare and ePMA schedule (in to prevent wards having to adopt more than one digital platform at a time). <p>Include within this schedule:</p> <ul style="list-style-type: none"> • Number of colleagues to train • Quantity/type of equipment to deliver <ul style="list-style-type: none"> • Training times • Post 'go live' support times <p>2. Development of processes required to</p>	Mr Aron White	31/12/2022	20/08/2025	Amber		<p>July 2024 IA tracker update:</p> <p>June '24 - Managed devices, using cisco solution and DHCW provided KPI certificates, are being tested. Further configuration required, but ePMA demo event and e-triage have needed to be prioritised for past 2months. Hoping device management team will be able to support imminently. Awaiting business continuity solution to be signed off by IG/Cyber.</p> <p>January 2025- Roll out complete at community hospitals and UHL. UHW implementation expected completion by May 2025. Progress is tracked at national service management board for WNCR.</p>

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Medical Equipment	The Clinical Engineering Department should liaise with Directorate and Ward Management on a planned and scheduled basis to confirm the ongoing existence and location of medical equipment items, to ensure the accuracy of the Medusa medical equipment database.	Initially, Clinical Engineering will perform an audit of items not seen for over 10 years. Confirmation of accuracy will be sought from Directorates and Ward Management. Depending on the results of this initial audit follow up audits will be scheduled on a regular basis.	Mr Ed Chapman	30/06/2025	01/09/2025	Amber		Acute workforce pressures are currently delaying implementation of this action	Nov 2023 Audit Committee update: No, a further extension to the implementation date is required. Feb 2024. [EC aDoTH 10/23] Please extend to May 2024 . The member of staff tasked with this (and other actions) has left since the July update and we are recruiting a replacement. Some preparatory work has begun on the audit, but operational pressures and lack of staff resource have delayed further progress. Implementation date changed to May 2023 to allow time to train staff and carry out work. [Jan 25] PowerBI software enviroment now working correctly, new target date of 30/06/25 [Aug 25] PowerBI dashboard link https://app.powerbi.com/groups/me/reports/a60da330-aa02-4c0a-93fedc3ba3b94d73/8e7341bc8ced03d46ad1?experience=power-bi now ready for beta testing with directorate managers.
Financial Management within Clinical Boards	Clinical Board Finance Senior Management need to work with Heads of Services/Departments to identify deliverable savings schemes in order to meet its delegated savings target for Corporate Central Savings Themes. Where existing savings schemes are failing to deliver their planned savings in total, Finance and Senior Management need to work with Heads of Services/Departments to identify actions that can be introduced to deliver the delegated savings targets. Where it has been identified/confirmed that identified schemes will not deliver expected savings then Heads of Services/Departments should ensure that additional deliverable savings schemes are identified to address the shortfall. Where non recurrent savings have been identified management should review schemes to ascertain if they could be made recurrent, or identify additional schemes.	The responsibility for delivery of the financial savings target is a key objective for the senior leadership team in each Clinical Board with the support and key input of the respective Finance Business Partner / Head of Finance. All savings targets for the UHB in the financial year are allocated to a Clinical Board level in the annual budget setting exercise as part of the development of the UHB financial plan. Finance Business Partners work with the Clinical Board leadership teams to continually develop savings ideas for Month 1 and then throughout the financial year. The Chief Operating Officer and Director of Finance, alongside the planning functions, ensure that the savings targets are shared and that plans are actively developed before the beginning of the financial year, and onwards into the financial year where shortfalls still exist. The delivery of the cost savings target is a fundamental, high risk, component of the financial strategy of the UHB and this is reflected in the UHB's Risk Register, monthly reports to the Finance Committee and Welsh Government. Alongside this the	robert mahoney	01/04/2024	23/10/2025	Amber	Non achievement of savings. Savings are risk rated Green, Amber and Red. Some Green and Amber rated savings will not be delivered in 2025-26 - Some Red rated schemes will come forward into delivery during 2025-26. Finance monitor and report this into Executives, Senior Leadership Board, Finance Committee and Welsh Government.	Ongoing service and demand pressures combined with inflationary pressures	This challenge relates to the 2024-25 financial year although the risk passes from year to year. In 2024-25 the UHB was able to meet the financial control total set by Welsh Government as a result of a range of measures which partially included the maximisation of the CRP delivery programme. In this sense the actions were complete with respect to the 2024-25 financial year. Ongoing in 2025-26 : This responsibility is an annual, key task for the UHB. The financial plan for the 2025-26 financial year projects a £58.5m deficit with the delivery of a £30m savings programme. It is important to note that this is not a plan that has been accepted by Welsh Government. The achievement of £30m savings in 2025-26 has been partially de-risked by the outputs from a 2 day Finance Summit held on 30 April and 1st May 2025. This leaves the UHB seeking broadly £5m of additional savings to meet the current 2025-26 savings target. The Senior Leadership Board meeting has taken the lead place to drive further progress. June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report. July 2024 IA tracker update: 1. Resource review undertaken, and recommendations being considered. 2. No change to implementation date. 3. No. 4. N/A
LIMITED Alcohol Standards	Management should consider completing a resource needs analysis to ensure that the SMLT are meeting the demand, and they are providing an effective service to meet needs of patients who have substance misuse issues.	SMLT to review where resource within the team is currently being utilised via a resource needs analysis and where there are currently gaps and proposals to address these, either singularly or in partnership with MH Liaison Team.	Desmond Collins	30/06/2024	12/06/2025	Red			

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IMTP Development Process June 2024	<p>Prior to resubmission of the IMTP to the WG the Health Board should undertake the following:</p> <ul style="list-style-type: none"> • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls. 	Management actions are as above in 2.1	Ashleigh O'Callaghan	30/09/2024	14/08/2025	Amber	The Annual Plan itself was submitted through all the relevant governance structures. The MDS and other mandated templates were reconciled by the core planning team and reviewed by Director of Finance, COO, Director of People and Culture prior to submission.
Capital Systems Management (Framework)	<p>Contract rates should recognise inflation as appropriate - Due to inflation and recognition of the time value of money in relation to the length of the framework (4 years + potential 2-year extension). A lesson learnt exercise should be undertaken now that the framework is operating to determine how attractive the framework is to contractors, reviewing uptake rates, whilst also confirming that the framework is operating as intended and continues to offer Value for Money (VfM). The Health Board have advised that they are undertaking a 'post implementation review' to ensure that the framework is successful from both a Health Board and contractor perspective.</p>	A lesson learnt exercise will be undertaken to establish whether the framework is operating as expected and fulfils the needs of the Health Board and contractors.	Mr Geoff Walsh	30/05/2025	07/11/2025	Amber	The new framework for contractors is now in place and appropriate changes were made to recognise the potential shortfalls in the initial framework to reduce the risk to the UHB
Mortuary Refurbishment at University Hospital Wales	<p>3.1 - The Project Execution Plan should be appropriately tailored to the UHB's internal control requirements, including for example:</p> <ul style="list-style-type: none"> • Project Governance structure, including role and function of the Project Board and Project Team, detail of the SRO and plans for the implementation of an Operational Group to manage operational commissioning; • Change Management process, including PIF process and delegated limits; and • Internal Risk Management process. <p>3.2 - The Project Team terms of reference and Project Team function should be reviewed, including:</p> <ul style="list-style-type: none"> • Whether ToR v2 needs updating to reflect additional members as agreed by the Project Team; and • Whether there would be a benefit to specifying a quorum. <p>3.3 - Project Team minutes should be filed within the project filing structure.</p>	<p>3.1 - Agreed.</p> <p>3.2 - ToR v2 will be updated to reflect the additional members agreed by the project team, and a specified quorum will be considered going forward on further schemes.</p> <p>3.3 - Agreed.</p>	Mr Stephen Gardiner	23/01/2025	28/08/2025	Green	All actions marked as complete within the 23.01.2025 Internal Audit report.

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Inclusion and Equality	<p>Management should ensure that a robust process is in place to enable the required action plans to be effectively developed and delivered.</p> <p>This should include effective structures to support the Inclusion and Equality Team, including development of the Inclusion Ambassadors and Equality sub-groups.</p>	<p>The review and refresh of the TORs of the EWSLGS (Action 1), will reinforce the reporting and local accountability against equality actions, while enabling a forum that shapes strategic direction against EDI (and Welsh Language). The reviewed TORs will include reporting accountability for Clinical and Service Boards, along with reporting to the People and Culture Committee, and Board.</p>	Mrs Claire Whites	31/08/2025	23/10/2025	Amber	<p>May 2024 IA tracker update: A Terms of Reference for a future iteration of EWSLGS has been drafted for consideration by the Health Board. However, a decision regarding the future of the group is currently on hold whilst considerations regarding the future of equity, equality, inclusion and its management within the Health Board are underway. Awaiting a decision from the Director of Corporate Governance.</p> <p>April 2025 Update: Meeting arranged for 10 April 2025 between Executive Director of People and Culture, the Director of Corporate Governance, and Head of Equity & Inclusion to discuss governance structure of equity and inclusion within the Health Board.</p> <p>October 2025 - please see update for previous action re EWSLGS. The UHB has introduced new governance arrangements that include the P&C Portfolio Board. These arrangements will ensure appropriate strategic and operational oversight.</p>
UHW Hybrid and Major Trauma Theatres	<p>4.1. The SCP Call off Contract will be resubmitted for signature by the UHB Chair.</p> <p>4.2. The UHB should confirm that appropriate insurances are in place in respect of the SCP.</p> <p>4.3. At future projects Contracts should be executed prior to the commencement of works / duties.</p> <p>4.4. At future projects All contracts should be dated.</p>	<p>4.1. Agreed - the SCP Call off Contract will be resubmitted for signature by the UHB Chair.</p> <p>4.2. Agreed the UHB will confirm at the earliest opportunity that appropriate insurances are in place in respect of the SCP.</p> <p>4.3. Agreed -Future Projects Contracts will be signed prior to the commencement of works.</p> <p>4.4. Agreed - Future Projects - Contracts will be dated.</p>	Mr Gavin Evans	31/10/2025	08/09/2025	Amber	<p>Scheme not yet approved by WG</p> <p>April 2025 - Actions 1 & 2 to be addressed once approval for the scheme has been given from WG. Actions 3 & 4 will be addressed on all future projects.</p>
Capital Systems Management (Framework)	<p>Framework contracts should be dated before commencement of the framework - Of the 30 framework contracts sampled, 4 in the largest size lot were undated (though each stated a framework end date). The contract seals were applied in April 2024, shortly after the Framework was launched. Confirmation was received that no works contracts were let with these contractors before the framework contracts were finalised.</p>	<p>Completed: The Health Board have reiterated policy in their new draft Capital Management Plan guidance to ensure that contracts are not undertaken off-framework without following appropriate Health Board procurement policies. Framework contracts will be signed, sealed and dated ahead of framework commencement and works undertaken under that framework for all future frameworks.</p>	Mr Geoff Walsh	20/01/2025	07/11/2025	Amber	<p>The improved governance arrangements introduced requires all contracts to be fully completed including dates prior to requisitions being raised on the oracle system</p>
Mortuary Refurbishment at University Hospital Wales	<p>WG PPRs should be updated at Section 11 to reflect the allocation of discretionary capital funds to the project budget, and the forecast outturn cost in total and under each budget area.</p>	<p>Information was provided in the narrative; however, the comment is noted and will be addressed going forward.</p>	Mr Stephen Gardiner	23/01/2025	28/08/2025	Amber	<p>Action marked as complete within the 23.01.2025 Internal Audit report.</p>
Capital Systems 2023/24	<p>Project Issues Form's will be completed for all project changes to demonstrate compliance with delegated limits.</p>	<p>Agreed – the Health Board have already commenced transitioning to this approach.</p>	Nigel Mason	30/09/2023	07/11/2025	Amber	<p>Project Issue Forms are completed on a not to exceed basis prior to works being undertaken by an external cost advisor, forms have been updated with the delegated limits</p>

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LIMITED Alcohol Standards	Management should implement the referral form as soon as possible in order to provide a consistent approach to the referral process and enable an audit trail of all referrals that have been made.	Referral processes to be standardised and recorded for all referrals made. To include reason and type of referral, any action taken, further referrals onwards or interventions given. Processes to be simple to follow and easily retrieved and accessible for monitoring and reporting purposes.	Lauren Idowu	30/06/2024	12/06/2025	Red	<p>June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report.</p> <p>July 2024 IA tracker update: 1. Substance Misuse Liaison Team (SMLT) have made improvements to the referral process. The Alcohol Programme Manager will continue to work on this action for further improvements.</p>
IMTP Development Process June 2024	<p>It is recommended that the Strategy Development and Delivery Group Terms of Reference state:</p> <ul style="list-style-type: none"> • The date that they have been approved and who approved them. • The date of next review and version number. • A clearly defined review procedure including auditable approval documents e.g. meeting minutes. 	<ul style="list-style-type: none"> - Terms of Reference are under review and will be presented to and signed off by Senior Leadership Board. - The approval date and approving body will be noted on the new terms of reference including the date of next review. - The terms of reference will include a review procedure. - Auditable documents will include meeting papers and action and decision notes. 	Ashleigh O'Callaghan	01/08/2024	14/08/2025	Amber	Terms of reference have been updated accordingly. Updates on an annual review cycle.
LIMITED Alcohol Standards	Management should review the current process and consider implementing a central database that includes the records of all appropriate staff across the organisation and detailing the alcohol awareness training undertaken, the date provided and the date for renewal.	Embed alcohol training within current training schedule for relevant staff and trainees. Ensure training records centralised and kept up to date, including dates for refresher training when required and what areas the staff work in.	Lauren Idowu	30/09/2024	12/06/2025	Red	<p>June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report.</p> <p>July 2024 IA tracker update:</p> <ol style="list-style-type: none"> 1. This action will be undertaken by the Alcohol Programme Manager post. 2. No changes to implementation date 3. None. 4. N/A
Legal Services - ADVISORY	We note that the Corporate Governance Team's remit in the legal service process is to ensure requests from across the Health Board have received the proper authorisation. The Health Board should consider if the Corporate Governance Team should receive operational activity information from Legal and Risk Services(NWSSP) given their limited role and whether this information should be shared to senior management of Clinical Boards/Corporate services who are actively involved in the detail of legal matters/cases.	To be picked up as part of the quarterly meetings between the DCG and NWSSP.	Miss Francesca Thomas	31/03/2025	26/06/2025	Green	Information is shared from NWSSP regarding statistics, figures, costs and themes for legal services for the UHB. There are opportunities for this to potentially be strengthened from NWSSP.
UHW Hybrid and Major Trauma Theatres	1.1 - The Project Execution Plan should be updated to reflect current governance arrangements.	Agreed – The Project Execution Plan will be updated. The project is currently on hold, subject to Welsh Government approval of the required funding. Therefore, whilst a July date is included as update they will not be ratified by the Group until the project re-commences.	Mr Gavin Evans	31/10/2025	08/09/2025	Green	April 2025 - The project is currently being reviewed following comments from WG asking the Health Board to review the scheme with a view to amalgamate with other Capital Projects. PEP will be updated by the PM following any changes.

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LIMITED Alcohol Standards	Management should consider the current situation and with alcohol levels rising and an increase in alcohol specific deaths there is a need for more leaflets and information to be available for patients at the Emergency Department and across the Health Board. There is also a need to have visible signposts to websites where more advice can be sought relating to the dangers of alcohol and where they can seek further advice or intervention.	Public Health Team to identify or produce resources (leaflets, posters, scratchcards, electronic materials/screens) on alcohol and signposting for patients. Alcohol Programme Manager to identify areas for these materials to be best placed for patients.	Lauren Idowu	31/12/2024	12/06/2025	Red	<p>June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report.</p> <p>July 2024 IA tracker update: 1. Not yet started.</p>
Medical Equipment	The Medical Equipment Group should review the current arrangements in place for evidencing and verifying that appropriate training of medical equipment is taking place, particularly for equipment classified as high risk.	The recording of medical equipment training will be discussed at the next MEG to agree on the best way forward and gather evidence of best practice. The existing training on high-risk devices such as Defibrillators, Infusion Devices, POCT and US will be shared with the MEG and MDSO groups to increase awareness. ECOD have some training records on ESR which will be evidenced on as part of this action.	Mr Ed Chapman	31/01/2025	01/09/2025	Amber	<p>Nov 2023 Audit Committee update: Implementation date moved to December 2023</p> <p>EC aDoTH 10/23] Practice education meeting has been re-instated, meeting was held 09/10/23, waiting to get ToR and attendance. SBAR for staff resource not proceeded with in current financial climate, review in next FY. Initial discussions seem to indicate Allocate (Health Roster) already has the competency module. Recommend moving implementation date forward 12 months to Dec 2025 or closing. We can provide evidence of training for high risk devices, ECOD do not have records themselves as far as we are aware.</p> <p>Progress report 06/2023, EC (aDoTH, Med. Equip.) is working with colleagues in Clinical Engineering and senior nurses in CD+T to re-establish the practice development network, linking in with ECOD. An SBAR for staffing resource to support a training records system is going to be produced. Recommend making this available to the project team.</p> <p>April 2025 - Terms of Reference will be developed in advance of the project team meeting and new project board as soon as the project is approved.</p>
UHW Hybrid and Major Trauma Theatres	3.1 - Terms of Reference for the Project Team should be developed and ratified.	Agreed- the Terms of Reference will be developed and ratified. The project is currently on hold, subject to Welsh Government approval of the required funding. Therefore, whilst an August date is included as an update, the ToR's will not be ratified by the Group until the project re-commences.	Mr Gavin Evans	31/10/2025	08/09/2025	Green	
Mortuary Refurbishment at University Hospital Wales	The UHB should liaise with the relevant frameworks and obtain assurance that appointed advisers hold (and maintain) appropriate Professional Indemnity Insurance for the period of the contract and thereafter.	The UHB will ensure a process is in place with procurement, so on further schemes insurances documents are included from the outset.	Mr Gavin Evans	31/03/2025	07/11/2025	Amber	Agreed. Head of Capital Planning to ensure that procurement confirm insurance documents are in place before progressing with any award.

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Mortuary Refurbishment at University Hospital Wales	<p>Lessons learned from the delivery of the Mortuary project should be documented, shared with relevant teams within the UHB, and reported to an appropriate forum (e.g. CMG/Programme Board). The issues considered may include for example:</p> <ul style="list-style-type: none"> The positive management controls applied at this project that would benefit application at future projects; assurance that arrangements are now in place to centrally hold the new build/survey information obtained from this project; the potential benefits of undertaking a wider review to identify any gaps in build/survey information across the site, to inform risk assessment of future projects; <ul style="list-style-type: none"> that at future projects that may be similarly impacted, time will be taken for appropriate intrusive surveys ahead of commencement of works; assurance that at future projects that may be similarly impacted, the UHB will ensure sufficient contingency is built into the business case, for consideration by WG; 	<p>Lessons learned from this scheme will be shared with other projects. It is difficult to ensure you have sufficient contingency built in to a project if you are not aware or are unable to reasonably assess the "unknowns". In this project was it reasonable to assume the depth of the slab, no, it had not been encountered within the UHW site previously or had been referenced on existing drawings. Therefore, without an intrusive destructive survey the slab depth was not known, a fair assumption was made and costs and design applied. The reason for the additional cost of this project has been well documented in reports issued to the Capital Management Group and the Senior Leadership Board of the Health Board, therefore the issues of the slab thickness have been well documented and recorded for future reference.</p>	Mr Geoff Walsh	23/01/2025	28/08/2025	Amber	Marked as complete within the 23.01.2025 Internal Audit report.	
LIMITED Alcohol Standards	<p>Management should consider extending the alcohol screening training sessions across the wider Health Board on signs to look out for when a patient is admitted. This would help raise the profile and identify patients who attend the Health Board outside of the Emergency Department who drink in a harmful way and ensure that they are treated in the most appropriate way.</p>	<p>Alcohol screening training (electronic) extended across wider Health Board staff. Information on alcohol, it's impact on health and screening and treatment services to be made available and promoted to all staff and departments, waiting rooms etc.</p>	Lauren Idowu	31/03/2025	12/06/2025	Amber	<p>June 2025 - actions marked as closed as have been superseded by the June 2025 Follow Up: Alcohol Standards Internal Audit report.</p> <p>July 2024 IA tracker update: 1. Online Alcohol Brief intervention content being developed via Public Health Wales. C&V Public Health Team are inputting. Alcohol Programme Manager will work to embed training once in post. 2. No change to implementation date. 3. None.</p>	
Core Financials 2024/25	<p>Debt Follow Up</p> <p>Testing was undertaken on a sample of outstanding debts to ensure that the process was being complied with. The following was noted:</p> <ul style="list-style-type: none"> 10 of the 20 sampled debts had either been paid or cancelled at the time of the testing. We note that all had been subject to the dunning process or the monthly statement process. For the remaining 10 debts, whilst the dunning process had been complied with in terms of issuing reminder letters not all the outstanding debts had been referred to the Health Board's debt collection agency as per the guidance in place. (We do acknowledge that the Health Board does not automatically refer outstanding debts to the 'agency' with each case judged on its own circumstances). We note that all 10 debts have been outstanding for a considerable period of time with some outstanding for more than 10 years. We also note that four of the 10 debts have been proposed for write off pending approval from the Clinical Board and a bad debt provision has been made for two of 	<p>We will undertake a review of all outstanding debts to determine actions to be undertaken.</p> <p>For those longstanding debts discussions will take place to determine whether these debts should be written off / provided for in accordance with Health Board guidance.</p>	Mrs Rebecca Holliday	30/09/2025	29/09/2025	Amber	<p>Please find attached the updated version of the original sample debts list. I've added a new column titled 'AR Comments' which includes a brief note on the current status of each item. Invoices over 10 years old are currently under review and will be actively pursued ahead of year-end. The number is expected to reduce significantly, aligning with internal audit action requirements.</p>	20250929094558_samplelist.xlsx

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University Hospital Llandough Endoscopy Development	The UHB should liaise with NWSSP Accounts Payable to highlight the importance of project payments being made in line with contractual terms, and identify whether a solution is feasible.	Agreed. Contact will once again be made.	Mr Gavin Evans	31/01/2024	07/11/2025	Amber	Discussed with CEF Business Manager and NWSSP appointed lead to ensure AP are briefed on the importance of meeting payment certificate dates.
University Hospital Llandough Endoscopy Development	On completion of the project, management should undertake a review of how the design / change process has been managed, with any lessons learnt identified for application at future projects.	Agreed. The Project Director has already challenged the number of PIFS raised at this project and requested a postproject review. However, it is important to note the project remains within budget and the finished product will meet the service requirements. The approach taken was tailored to the style of the project contractor. We are also reviewing our approach to budget management with this Contractor: preparing our own estimates rather than awaiting the Contractor to cost the PMIs. This will improve our ability to make informed decisions based on greater cost certainty surrounding.	Mr Gavin Evans	31/01/2024	07/11/2025	Amber	This has now been actioned with not to exceed budget estimates being used on PIFS.
University Hospital Llandough Endoscopy Development	The UHB and external Project Manager should support the change management process by completing the following activities in a timely manner: • approving PIFs; • accepting quotes (via PMN); and • ensuring PMNs are not issued until PIFs have been approved.	Agreed. As referenced at management response 5.1, we are implementing a new process of forecasting PIF costs internally, rather than awaiting contractor quotations. This will allow a more timely review of the change and likely budget implications, with the instruction issued once the quotation is received and agreed.	Mr Gavin Evans	31/01/2024	07/11/2025	Amber	The UHB project liaison officer and head of capital planning now ensure that the above processes are all now followed in a timely manner on current Health Board projects.
University Hospital Llandough Endoscopy Development	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	1 - Agreed. We have received verbal assurance from the Endoscopy Department that the warranty period is three years, therefore there is no risk to this expiring prior to installation. 2 - Agreed. We recognise this would be an enhancement at future projects, where applicable. 3 - Agreed	Mr Gavin Evans	31/01/2024	07/11/2025	Amber	1. Equipment warranty was discussed with the supplier and no issue was raised with extending the equipment warranty. 2. Accepted, to be monitored on future projects. 3. Accepted, to be actioned on future projects.
University Hospital Llandough Endoscopy Development	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	1 - Agreed. We have commenced maintenance of KPIs, based on the Designed for Life Framework as a starting point, and will work on enhancing this process as it progresses. The process includes reporting to the Director of Capital & Estates, with an escalation process where needed. 2 - Agreed - recognising this will be tailored to each project and advisors as appropriate – less complex schemes / appointments can still be managed via the SLA.	Mr Gavin Evans	31/01/2024	07/11/2025	Amber	KPI's are now included within the Cardiff and Vale 2nd Generation Building works framework that closes off this item. NEC4 PSC are now being considered for use with external advisor appointments.

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Inspection Title	External Inspection Lead	Inspection Date	Recommendation	Action	Person Responsible	Due Date	Date Last Updated	Last Updated By	Action Rating	Progress Status	Progress Status Reason	Risks	Barriers	Comments/Updates	Evidence
Inclusion and Equality	Executive Director of People and Culture	27/04/2023	A review of the Terms of Reference along with the membership and remit of the ESWISG is required by management, along with the formation of subgroups to facilitate decision-making and implementation.	The Terms of Reference, including membership and governance requirements of the ESWISG are currently under review. This review will be informed by the governance surrounding the UHB's Equality, Equity and Experience Framework (currently at consultation), the requirements of the People and Culture Committee and the outcome of this audit. This review will include the identification of any required sub groups / steering groups / working groups and subsequent membership requirements and TORs.	Mrs Claire Whiles	31/08/2025	23/10/2025	Mrs Claire Whiles	Amber	Unable to complete	The change in reporting and creation of Portfolio Boards has led to this particular action now being obsolete. The UHB has newly created governance arrangements via the P&C Committee, and the P&C Portfolio Board that provide strategic and operational oversight to this work.			May 2024 IA tracker update: The Terms of Reference for a future iteration of ESWISG has been drafted for consideration by the Health Board. However, a decision regarding the future of the group is currently on hold whilst considerations regarding the future of equity, equality, inclusion and its management within the Health Board are underway. In the meantime, matters in relation to equity, inclusion and the Welsh language are reported directly to the People & Culture Committee. The Head of Equity & Inclusion is a regular attendee at the committee. Awaiting confirmation from the Director of Corporate Governance. April 2025 Update: Meeting arranged for 10 April 2025 between Executive Director of People and Culture, the Director of Corporate Governance, and Head of Equity & Inclusion to discuss governance structure of equity and inclusion within the Health Board.	
IMTP Development Process June 2024	Ashleigh O'Callaghan	14/06/2024	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	Ashleigh O'Callaghan	30/09/2024	08/08/2025	Ashleigh O'Callaghan	Red	Unable to complete	The MDS was reconciled with the IMTP by the Core Planning Team prior to submission and reviewed by the Executive Directors of Finance, Planning, People and Culture, and the Chief Operating Officer. However, it was not independently reconciled and the MDS was submitted to the Senior Leadership Board, Finance and Performance Committee, or the Board for formal approval. This approach was taken for two key reasons: 1. Timing Constraints: The MDS is finalised as close to the submission deadline as possible to ensure it reflects the most up-to-date position, including the latest savings figures and decisions on workforce, finance, and activity assumptions. This limited the time available for an independent review, requiring a balance between additional assurance and the need for timely, accurate, and triangulated data. 2. Nature of the Document: The MDS is a technical spreadsheet that underpins the broader plan. An agreement was reached				
Cancer Services	Chief Operating Officer	01/05/2024	1. A system-wide project should be undertaken with the aim of improving integrity/quality for Suspected Cancer Pathway data. 2. Management should undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit.	1. Cancer Services, led by the General Manager for Cancer Services will deliver on a continual improvement plan for refining and improving the quality of the SCP cancer data set. Aspects of this are outlined within the digital plan within the cancer strategy. 2. The Cardiff and Vale UHB Cancer Strategy 2023-2028 identifies "Adopting Digital First" as a key component. In December 2023 the 1, 3 and 5 year priorities were presented and agreed outlining the direction towards refining and improving the IT infrastructure, reducing duplication and automation of data collection. As part of this work, a gap analysis was undertaken specifically around digital requirements. The Executive Cancer Board will act as the overriding governance structure monitoring the delivery against these key objectives.	Michael Eastwell	30/05/2024	12/05/2025	Ms Rachel Chilcott	Red	Unable to complete	A gap analysis has been completed and business case to address gap presented to cancer network however not approved. Further ability to influence IT infrastructure is severely limited however will continue to advocate for cancer on the IT work program	Business case to address IT shortfall in tracking was submitted to the WCN recover program but rejected. They are planning on creating a program to address the issue nationally	This action reflects a continual pathway of improvement that will be gradually implemented over a period of 5 years. Implementing next steps is reliant on completion of the CANISC replacement. This action will be continually revisited through the executive cancer board July 2024 IA tracker update: 1. Implementing this action is dependent on the wider digital transformation programme which we are supporting from a cancer perspective. A meeting was held 05/06 to establish the vision for automation of cancer tracking which will resolve many of the challenges outlined by removing the need for manual trawling of separate data systems. This work is achievable but reliant on the completion of the current CANISC replacement project. This is a 1.5/2 year planned programme of work but will carry many benefits including enhanced data accuracy, timeliness of tracking and staff resource. 2. progress against this action will be delivered ahead of 2028. 3. The primary challenge for this action is	20250421143031_cancerdataandintelligen (c)prtransformation/businesscasefinal.docx	

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IMTP Development Process June 2024	Ashleigh O'Callaghan	14/06/2024	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: <ul style="list-style-type: none"> • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks. 	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	Ashleigh O'Callaghan	30/09/2024	08/08/2025	Ashleigh O'Callaghan	Red	Unable to complete	The Minimum Data Set (MDS) was not delegated to the Finance and Performance Committee based on both practical and governance considerations. 1. Timing and Finalisation Constraints The MDS is finalised as close to the submission deadline as possible to ensure it reflects the most current and accurate position. This includes the latest savings figures, workforce decisions, financial assumptions, and activity projections. The compressed timeline does not allow for the additional step of committee review without compromising the currency and relevance of the data submitted to Welsh Government. 2. Nature of the MDS as a Technical Document The MDS is a detailed technical spreadsheet that underpins the broader organisational plan. It is not a standalone strategic document requiring formal approval, but rather a supporting dataset. As such, an agreement was reached between the Head of Planning, Director of				
LIMITED - Local Data Repository	Director of Digital and Health Intelligence	17/04/2025	There is no IG framework for the LDR and no DPIA that assesses the impact of the LDR. We also note a lack of a data governance process that sets out the requirements for data quality and maintenance, with no reference to data governance within the LDR plan.	Ensure the artefacts defined at a programme-level provide a suitable baseline from which DPIA and cyber security compliance can be documented. Without appropriate Programme artefacts, that have been approved through the formal governance processes, both IG and Cyber will have dependencies on details that will not be available.	Mr James Webb	30/09/2025	13/08/2025	Mr James Webb	Red	Unable to complete	As stated in the management response, the 'artefacts' of the LDR have still not been defined by the LDR team and therefore we are unable to provide advice on the appropriate governance framework and there is currently nothing to assess.				
Paris System	Director of Digital and Health Intelligence	09/10/2023	Management should liaise with Civica with a view to moving system back-ups off-site.	We strongly agree with this recommendation, in fact it was identified during a recent hardware refresh but no suitable offsite location was found due to numerous reasons (CRI lacking capacity and Woodlands House lacking redundant power). We will use this recommendation as a springboard to address the matter urgently however, the target date will be within 6 months due to factors such as complexity, availability and financial constraints. We will work with the head of digital operations and Civica to identify a suitable offsite backup location and relocate. We will also look to identify if there are any immediate actions that we can take to mitigate the risk in the meantime.	Katherine Roscoe	01/04/2024	12/05/2025	Ms Rachel Chilcott	Red	Unable to complete	1. Financial sustainability and lack of funds within the MHCS budget within the short term - we already have cost pressures from the vendor software contract. 2. Medium-term, our vendor software contract terminates 31/03/2028. We are looking to implement a replacement Mental Health and Community EPR system that will either be cloud-hosted, negating the need for this requirement, else will have funding provision for new replacement hardware infrastructure which would address this issue.	1. Financial risk - limited programme budget. 2. Risk of delays due to insufficient staffing resource (sickness, annual leave, etc.). The solution itself is not without risk: Risk of network link failure/downtime. Risk of catastrophic equipment failure (fire, flood, etc.).	Financial barriers - we are awaiting confirmation of the cost of setting up CRI as a secondary backup location. The PARIS Programme budget is limited, hence this may not be financially viable within the current budget.	Jun'24: Contract still to be finalised, once finalised we will look to move this forward with CIVICA. In the mean time we will liaise with digital ops team to determine if any offsite locations have suitable capacity. Hardware migration is completed and decommissioned. Aug'24: Application Manager in talks with Digital Ops and Civica to arrange. CRI has been identified as a suitable location but we have been told this will likely come at a cost to set up.	

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Inspection Title	Inspection Date	Recommendation	Action	Original Due Date	Current Due Date	Action Rating	Progress Status	Risks	Barriers	Comments/Updates
Structured Assessment 2024	31/10/2024	Risk Management - The Health Board should refresh the Risk Management Strategy to ensure it includes new arrangements for recording and escalating operational risks.	This will follow the completed transfer of all registers to a single one on AMAT.	31/03/2025	31/12/2025	Amber	In progress			<p>May 2025 - digital risk management project is underway and a focus on the pace of this work will be scrutinised in Clinical Board reviews from July 2025. The Risk Management Policy/Strategy will be refreshed accordingly once this process has been completed.</p> <p>Aug 2025 - Digital Risk Management Task & Finish group launched in July 2025. Implementation plan now being worked up with Clinical Boards & Corporate Teams to migrate all organisational risks into AMAT, starting with the Corporate Risk Register (CRR) (risks scored 20+). T&F will now meet monthly with the aim of all CRR migrated by end of October 2025 in readiness for a moderation at SLT in November 2025.</p> <p>Oct 2025 - refresh of Risk Management Strategy & Policy due Q4 / Q1 2026/27 following completion of all UHB risks migrating onto AMAT. This will also be audited by Internal Audit in Q4.</p>
Primary Care Follow-up	30/04/2024	New ways of working The Health Board should: 2.1 Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; 2.2 Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; 2.3 Subject to positive evaluation, begin to fund new models from mainstream funding; and 2.4 Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce the demand for GP appointments.	<ul style="list-style-type: none"> - This work is already underway locally. - The National Accelerated Cluster Development (ACD) Programme facilitates Primary Care Clusters, made up of health and care professionals, to work across service boundaries to influence the development of services for their patients. - The plan of the Pan-Cluster Planning Groups (PCPG), covering both Cardiff and Vale regions, will progress work during the 2024 planning cycle to inform whole system efficiency and effectiveness opportunities from the lens of Primary Care, informed by current legacy/recurrent cluster delivered schemes with a strong evidence base for scalability. - A paper is to be provided to Cardiff and Vale Senior Leadership Board in May 2024, setting out the work of Clusters and Pan Cluster Planning Groups to date. - Development sessions are planned during Quarter 1 2024 to develop resources to further support evaluation and to further establish Cluster and Pan Cluster Planning Groups as part of the UHBs planning architecture. - New models/schemes to be prioritised for 	31/12/2024	31/03/2025	Amber	Partially complete (Overdue)			<p>Work continues to develop a consistent evaluation framework to be used by Clusters, which can form the basis of business cases for investment.</p> <p>Pan Cluster Planning Groups are yet to be fully established and functioning in line with the vision set out by the Strategic Programme for Primary Care, however this position continues to be communicated with Executive Team colleagues, and an intent to establish the governance and role of pan cluster planning within the Health Boards planning architecture.</p> <p>Cluster based schemes continue to be promoted through available channels and further Cluster based initiatives have been prioritised for support which includes roll out of Paediatric Integrated Clinics, and progress of Connected Community based MDTs and Integrated Care Hubs as part of the Health Boards goal to become an integrated community care system.</p> <p>Primary Choice continues to be used, promoted and enhanced to support patients and citizens with access, including the development and sharing of resources across Primary Care contractor sites, within community hubs/venues such as Library's, and through engagement with Llais representatives to cascade materials to help individuals understand different access choices available. Further work has been commissioned within South East Cardiff to understand barriers to access and will be used to inform communication materials. We will</p>
Review of Quality Governance Arrangements	01/06/2022	Resources to support quality governance - Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.	2. Management of resources through the pandemic was challenging for the Infection Prevention and Control team. However as the pandemic reduces the focus for the IPC team is back on normal tier 1 IPC targets, we are now seeing the move back to normal business. Active recruitment also in place to recruit to outstanding vacancies.	30/09/2022	31/03/2026	Red	In progress	With 3 nurse and a PA/Administrator vacancies there is insufficient support available within the IP&C team to provide adequate support to the Clinical Boards. The number of audits undertaken by the IP&C team will be reduced as will the number of education sessions provided	Admin post vacancy rejection is putting more strain on a team that are extremely busy and short staffed as the nurses are havint tp arrange and administrate their own meetings	<p>The recruitment process is underway for a band 6 ACNS in IP&C, interviews will be held W/c 08/09/2025. However since that post became available 2 other members of the team have left leaving a band 6 and a band 7 ACNS and CNS posts vacant. A request to recruit is in progress</p> <p>The PA/Administrator for the IP&C team left the post in July, the vacancy request to replace her was rejected and had to be resubmitted</p> <p>28/10/2025 UPDATE- The band 6 posts were initially rejected at scrutiny however the request was successful and both are in the recruitment process at present. The band 4 administrator post has been rejected twice at scrutiny panel, the request will be resubmitted as the lack of an administrator is putting extra strain on a team that is extremely short staffed due to the vacancies and sickness within the team</p> <p>## Action date extended to review in March 2026 following progress of recruitment as outlined above ##</p>

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Review of Quality Governance Arrangements	01/06/2022	Risk Management - There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risk registers and the escalation and de-escalation of risk to/from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risk registers and introduce an appropriate process for the escalation and deescalation of risk to/from the Corporate Risk Register.	a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality, Safety and Experience Committee.	31/10/2022	31/03/2026	Amber	Partially complete			Update Sept 2025: the roll out of AMaT risk register module is underway, and it's use will be fully integrated into the clinical safety group ensuring oversight of clinical risk, mitigation and development of strategy through the clinical advisory groups. The clinical safety group is continuing to evolve and until this is fully embedded this action will remain as partially complete. clinical boards are currently migrating their risk registers onto AMaT and all corporate risks are now on AMaT ## Action date extended to March 2026 to re-review pending migration of all outstanding risk registers to AMAT from across the UHB ##
Review of Quality Governance Arrangements	01/06/2022	Resources to support quality governance - Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.	4. The corporate team will work with the clinical board to identify QSE leads and responsibilities with an exercise to identify the time required to effectively deliver these agendas. This work will be undertaken over the next 2 months and all corporate clinical safety groups updated	31/10/2022	31/03/2026	Red	Partially complete			Update Sept 2025 - a paper has been completed determining the resources required from each CB to ensure adequate medical engagement in the quality agenda, this includes involvement in patient safety incidents, presentation in clinical advisory groups and specialist lead roles across the organisation. CBs will need to consider the implications of this paper on their resources and job planning. ## Action date extended to review in March 2026 ##
Audit Wales - Audit of Accounts Report Addendum for 2022-23	01/08/2022	Weaknesses in network security vulnerability assessments: The Health Board should strengthen its assessment of network security vulnerability by: • completing regular external penetration testing on the network perimeter, including at least annually by an accredited third party; and • actively monitoring the internal network penetration testing to promptly identify and address any weakness.	The UHB is currently in the process of appointing a dedicated cyber team. Two positions have been filled and we are recruiting a further two posts. An externally performed penetration test is being scheduled for Q4 of 2022/23. Once the cyber posts are in place, we will be in a position to proactively use a number of cyber tools at our disposal. This includes: SIEM, which is currently operational and staff are in the process of being trained. Defender for Endpoint, currently in the process of being onboarded and, Nessus, operated by the server team but will be supported by the cyber department. We anticipate that all roles will be appointed to by Q3 of 2022/23.	31/03/2023	31/03/2026	Red	Partially complete			June 2024 update: Cyber Security Lead appointed in May 2024. Whilst adhoc pen tests occur, we plan to work up a regular pen test schedule. November 2025 - cyber team is fully resourced and all positions fulfilled. routine monitoring of network tools are undertaken but PEN tests remain very adhoc due to the operational challenges and logistics of managing such a large estate. Some key infrastructure has been pen tested including Remote Desktop Services (RDS). This action is linked to the cyber resilience unit which is part of DHCW which is due to be issued shortly. ## Action date extended to 31 March 2026 to review pending outcome of CRU audit ## Head of IG now action lead

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<p>Audit Wales - Audit of Accounts Report Addendum for 2022-23</p>	<p>01/08/2022</p>	<p>Progress against previous years' recommendations: The quality of some of the Health Board's underlying working papers requires further improvement</p> <ol style="list-style-type: none"> 1. 2019-20: The Health Board should review and simplify its supporting records for certain areas of its annual financial statements, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand how some of the documentation affects our audit. 2. 2020-21: The Health Board should replace its unsupported Windows 2008 servers and W7 devices. 3. 2020-21: The Health Board should update and test its IT Disaster Recovery Plan (DRP) to gain assurance that IT systems can be restored if needed. 4. 2020-21: The Health Board should update its IT change-control policy and procedure. 5. 2020-21: The Health Board should evaluate and consider upgrading its IT1 	<ol style="list-style-type: none"> 1. The Health Board improved some of its processes and records for 2021-22 and we understand that it plans more improvements for 2022-23. We will continue to liaise with the finance team on the improvements. 2. The Health Board has an ongoing programme in place to replace or upgrade all affected devices. 3. The Health Board is reviewing and updating its IT DRP as part of a programme to refresh its IT security documentation. 4. The Health Board is updating its change control policy as part of its new helpdesk system. 5. The Health Board is currently reviewing its data centre rooms and is considering whether to decommission some of them. 	<p>31/03/2023</p>	<p>31/03/2026</p>	<p>Red</p>	<p>Partially complete</p>			<ol style="list-style-type: none"> 1. Ref : Financial Accounts Issues --Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines. Update Nov 25 - every year Finance work with AW to review and improve how information is provided to audit. This recommendation relates to 19-20 which was the first year of conducting the finance audit in line with covid restrictions. 2. Work to replace Win7 devices is complete. work to replace 2008 server estate is on-going due to clinical service dependencies (additional controls have been put in place in the interim, pending migration and replacement). Nov 25 update - in the progress of replacing all windows 10 devices and legacy servers still exist. 3. The DR plan has been updated and is scheduled to be tested (Qtr4 22/23) Nov 25 update- Disaster recovery policy to be considered by digital committee in Nov 2025. DR plan needs to be updated. The oracle system is now no longer hosted internally , in October 2024 this moved to be hosted in a cloud based system with the fall out locations now being in London & Newport rather than in the CRI. There is due to be a DR test in November 2025, therefore these tests are happening. 4. IT change control policy and procedure has been produced in draft, which will be published by end Qtr4 22/23). 5. The IT1 DC is being consolidated into IT2 with a second site identified and being set up as additional resilience (in by Qtr4
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Inspection Title	Inspection Date	Recommendation	Action	Person Responsible	Due Date	Action Rating	Progress Status	Risks	Barriers	Comments/Updates	Evidence
Clinical Coding Follow-Up from 2014 not yet completed	10/01/2020	<p>Medical Records</p> <p>Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include:</p> <p>a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards;</p> <p>b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS);</p> <p>c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW;</p> <p>e) reducing the level of temporary medical records in circulation;</p> <p>f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and</p> <p>g) revisiting the availability of training on</p>	<p>b) To facilitate the achievement of the Welsh Government target that 95% of coding activity should be completed within one month of the end of the hospital episode, it is important that clinical coders get timely access to the patient's medical records. From our last review we found that tracking of records was an issue. If records are not tracked effectively this means it can take longer for coders to access them. Coders are reporting that they are tracking records, however practices across the Health Board are not consistent and still cause issues.</p>	Mr Sion O'Keefe	05/05/2024	Red	Partially complete (Overdue)			<p>June 2024 Update: The Clinical Coding function transferred to CD&T in 2023</p> <p>May 2023 Update: From the 5th June 2023 all filing libraries are being restricted so that only medical records personnel retain access which should improve compliance with the WG target for coding activity.</p>	
Structured Assessment 2023	30/12/2023	<p>Well-being Objectives - Whilst the Health Board's new well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner organisations.</p>	<p>Consider incorporating additional priorities that encompass all aspects of sustainable development, particularly those that relate to the environment.</p>	Miss Francesca Thomas	02/07/2024	Amber	Overdue			<p>Update at 02/07/2024 Audit Committee paper - (a) Some of the wider aspects, such as biodiversity, are being incorporated under the decarbonisation action plan as a priority within objective 4 (Acting for the future); however, we will review our strategic approach through the reconstituted UHB WFG Group (chaired by the Exec Director of Public Health) and in conjunction with Strategic Planning to ensure all aspects of sustainable development are represented across the organisation's strategic portfolios.</p>	
Review of Cost Savings Arrangements CAVUHB	16/01/2025	<p>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.</p>	<p>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.</p>	Andrew Gough	31/01/2025	Amber	Overdue			<p>07.01.2025 - There has been a rolling expansion in personnel in the Chief Operating Officer's department to help better deliver performance in activity and effective use of resources. The UHB continues to support a Shaping Change and an Innovation team. These have been heavily involved in delivering a pan UHB Rapid Delivery Event in December 2024 involving 200 leadership colleagues.</p> <p>22/10/2025 - The UHB continues to support capacity and capability to deliver longer-term service objectives. This is an ongoing action.</p>	

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Primary Care Follow-up	30/04/2024	New ways of working The Health Board should: 2.1 Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models; 2.2 Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters; 2.3 Subject to positive evaluation, begin to fund new models from mainstream funding; and 2.4 Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce the demand for GP appointments.	- This work is already underway locally. - The National Accelerated Cluster Development (ACD) Programme facilitates Primary Care Clusters, made up of health and care professionals, to work across service boundaries to influence the development of services for their patients. - The plan of the Pan-Cluster Planning Groups (PCPG), covering both Cardiff and Vale regions, will progress work during the 2024 planning cycle to inform whole system efficiency and effectiveness opportunities from the lens of Primary Care, informed by current legacy/recurrent cluster delivered schemes with a strong evidence base for scalability. - A paper is to be provided to Cardiff and Vale Senior Leadership Board in May 2024, setting out the work of Clusters and Pan Cluster Planning Groups to date. - Development sessions are planned during Quarter 1 2024 to develop resources to further support evaluation and to further establish Cluster and Pan Cluster Planning Groups as part of the	Ms Emma Lewis	31/03/2025	Amber	Partially complete (Overdue)			Work continues to develop a consistent evaluation framework to be used by Clusters, which can form the basis of business cases for investment. Pan Cluster Planning Groups are yet to be fully established and functioning in line with the vision set out by the Strategic Programme for Primary Care, however this position continues to be communicated with Executive Team colleagues, and an intent to establish the governance and role of pan cluster planning within the Health Boards planning architecture. Cluster based schemes continue to be promoted through available channels and further Cluster based initiatives have been prioritised for support which includes roll out of Paediatric Integrated Clinics, and progress of Connected Community based MDTs and Integrated Care Hubs as part of the Health Boards goal to become an integrated community care system. Primary Choice continues to be used,
Review of Cost Savings Arrangements CAVUHB	16/01/2025	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R2.1 - Extending its use of data and intelligence across a wider range of services. R2.2 - Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. R2.3 - Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas.	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R2.3 - Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas.	Mr David Thomas	31/03/2025	Amber	Overdue			07.01.2025 - A Data Insights Programme Board has been established, chaired by Director of Digital & Health Intelligence, the aim of which is to oversee and sign off internal data insights and reporting capabilities with broad representation from across corporate services and clinical boards. This plans to train up business intelligence partners and to deploy and train appropriate staff on Power BI as well as pursuing the data democratisation agenda.
Review of Cost Savings Arrangements CAVUHB	16/01/2025	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 underdelivery or where savings requirements change in-year.	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 underdelivery or where savings requirements change in-year.	Andrew Gough	31/03/2025	Amber	Overdue			07.01.2025 - That is always the intention. Internal planning guidance issued for 2025/26 aims to bring the planning timetable forward with an ambition of having a fully developed savings plan in place prior to 1st April. 29/08/25 - The Health Board acknowledges the recommendation and has taken steps to strengthen its approach to savings planning and risk mitigation for the 25/26 financial year. The savings planning process for 25/26 commenced earlier than in previous years, allowing more time for scheme development, challenge and refinement. This has supported increased progress against the savings target at this point of the year compared to previous years. There has been an increased emphasis on the review of Red and Pipeline savings schemes to ensure viability and progress. The Health Board has started work on an Efficiencies Compendium which will support identification of a rolling programme of schemes to support the Financial position.

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Urgent and Emergency Care: Flow out of Hospital - CAV Region	30/09/2024	Improving compliance with policies and guidance	R2 - The Health Board, working with local authorities, should update its discharge policy and associated policies, including the choice of accommodation policy, to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023, set out clearly defined roles and responsibilities, and expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers.	Ms Diane Walker	30/04/2025	Amber	Overdue			AW Organisational Response - i. The Health Board is developing a new discharge policy to include the key elements from the most recent national discharge guidance in September 2024. The policy is being developed with input from local authorities. ii. The policy will be reviewed by the partnership governance arrangements through the Strategic Leadership Group. iii. Advice and support will be sought from Liaison on involvement of patients and carers.
Urgent and Emergency Care: Flow out of Hospital - CAV Region	30/09/2024	Maximising the use of the Regional Integration Fund	R7 - To help inform decision-making and discussions, the Health Board and local authorities should ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages.	Ms Diane Walker	30/04/2025	Amber	Overdue			AW Organisational Response - i. POCD data is currently regularly shared with the RPB Strategic Leadership Group through both specific programme reporting and CAC priority briefings. ii. The RPB team will review the key performance indicators already collected and ensure they are shared in the appropriate forums.
Review of Cost Savings Arrangements CAVUHB	16/01/2025	The Health Board should set challenging but realistic targets for its individual savings schemes and manage risks to under-delivery more effectively.	The Health Board should set challenging but realistic targets for its individual savings schemes and manage risks to under-delivery more effectively.	Andrew Gough	30/04/2025	Amber	Overdue			07.01.2025 - This has been a communicated position in savings delivery aspirations to date recognising the risk that not all schemes will be delivered or, if delivered, not necessarily within the timescale or value initially projected. The savings tracker that is updated weekly, using the Green/Amber/Red ratings assurance, is used nationally within Wales. Based on a rolling scrutiny and reporting cycle, a re-energisation process takes place in year to secure new schemes to replace deficits. 29/08/25 - The Health Board acknowledges the recommendation and is committed to setting savings targets that are both ambitious and achievable, which strengthening management of delivery risks. Savings schemes involve close collaboration between finance and service teams to ensure targets are grounded in evidence and operationally deliverable. In 2025, the Health Board held a series of Finance Summits to challenge the identification of savings schemes and promote ambition within operational
Review of Cost Savings Arrangements CAVUHB	16/01/2025	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R2.1 - Extending its use of data and intelligence across a wider range of services. R2.2 - Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. R2.3 - Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas.	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R2.1 - Extending its use of data and intelligence across a wider range of services.	Andrew Gough	31/05/2025	Amber	Overdue			07.01.2025 - The UHB has good sources of data on Benchmarking via its Value Team including CHKS and the Financial Delivery Unit Vault data. The Finance Team is developing a more balanced monthly resource report pack to introduce key CHKS opportunities data into monthly reporting in 2024-25 as part of its 'Changing the Conversation' reporting programme. 29/08/25 - The Health Board acknowledges the recommendation and recognises the importance of using robust data and intelligence to inform the identification and selection of savings opportunities. To support this the Health Board is developing an Efficiencies Compendium with support from the Financial Performance and Delivery Unit. This will build on the work through the national VAULT resource. This resource will consolidate best practice, benchmarking data and evidence-based opportunities for efficiency across a wide range of services, supporting more informed and consistent savings planning.

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Tackling the Orthopaedic Services' Waiting List Backlog	28/02/2023	The Getting It Right First Time reports set out clearly a range of recommendations which will help drive improvements in efficiencies and productivity in orthopaedics at a local level.	We recommend that health boards need to: a) ensure they maintain oversight and scrutiny of implementation of the Getting It Right First Time recommendations as part of their governance arrangements; and b) ensure that clear action plans are in place to address the things that get in the way of improvement.	Mr Antonio Roccioni	12/06/2025	Amber	Overdue				
Tackling the Orthopaedic Services' Waiting List Backlog	28/02/2023	Clinical Musculoskeletal Assessment and Triage Services (CMATS) are having a positive impact on managing demand and providing support. But services are struggling with capacity and are inconsistent in their delivery with examples of duplication of effort where First Contact Practitioners (FCPs) exist.	We recommend that health boards need to: a) ensure that local CMATS are appropriately staffed, and at a minimum, reflect previous Welsh Government guidance; and b) ensure that where First Contact Practitioners (FCP) exist, there are clear pathways between FCPs and CMATS to reduce duplication and minimise waits.	Dr robert letchford	12/06/2025	Amber	Overdue	Risk of increasing demand on CMATs from CP01 implementation which risks, timely, effective care However this needs to be balanced by the more significant current risk of people waiting years for spinal surgery and the risk of long term and permanent dissability.	resources shifting within system to follow the demand- potential for new resources to "right size"	A CMATS was originally commissioned in CAVUHB for knee, spine and shoulder only. other body regions (hands, feet and hips) were not included and have continued under orthopaedic governance structures The spinal system has recently been superseded by the South Wales spinal Network CP01 which is in the implementation phase under the guidance of the MSK delivery group reporting into the Planned care transformation fund. That guidance also calls for "right sizing" of CMATS and delivery group have agreed to scope the whole pathway to understand the "right size" of all components. Data so far suggests a shortfall in CMATS for spinal pain of 2000 NP per annum under current demand and that this is likely to rise by a further 2400 per annum under the new spinal guidance from CP01 The Knee and shoulder elements are expected to be similarly short, and also to be impacted by guidance that is due soon - we will follow similar modelling when that	
Tackling the Orthopaedic Services' Waiting List Backlog	28/02/2023	There needs to be a greater focus on outcomes across health boards and while people are deteriorating on orthopaedic waiting lists, limited progress has been made by health boards to provide ongoing support and monitor and report harms.	We recommend that health boards need to: a) ensure that Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are fully rolled out in all orthopaedic services and used to inform decision making both at a service and patient level; b) ensure that local clinical leadership arrangements and performance information are used to identify opportunities for minimising interventions that are unlikely to result in improved outcomes; and c) put arrangements in place to monitor people waiting, provide communication, support and advice when needed, and report openly and honestly, through their existing governance arrangements, the extent to which people are coming to harm whilst waiting for orthopaedic treatment.	Phil Thomas	12/06/2025	Amber	Overdue				

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Review of Cost Savings Arrangements CAVUHB	16/01/2025	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.	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.	Andrew Gough	30/06/2025	Amber	Overdue			07.01.2025 - Work is ongoing on a long-term financial model for the health board to support the financial sustainability agenda. Value and transformation offers great opportunities to deliver services that are more effective and offer greater value for money albeit this does not always offer a scale of savings to address the University Health Board's (UHB)'s annual requirement of savings. 26/08/2025 - The Health Board acknowledges the recommendation and has established a Value and Benefits Realisation Group (VBRG) to provide oversight and assurance on the delivery of both financial and non-financial benefits from transformation programmes. The VBRG places an emphasis on affordability, value and alignment with strategic direction, ensuring clear baseline positions are articulated and anticipated benefits of investment, disinvestment or reallocation decisions are understood. The group undertakes post implementation reviews of all significant resource decisions to ensure they
Review of Cost Savings Arrangements CAVUHB	16/01/2025	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R2.1 - Extending its use of data and intelligence across a wider range of services. R2.2 - Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. R2.3 - Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas.	The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by: R2.2 - Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data.	Mr David Thomas	30/06/2025	Amber	Overdue			07.01.2025 - The local data repository development plan includes delivery of a stable Local Data Repository infrastructure (currently in proof of concept) and integrating new systems including Electronic Prescribing and Medicines Administration (EPMA e-prescribing), Patient Reported Outcome measures (PROMS) and AQUA Theatreman (theatres system). Longer term plans are to ingest many more different data sources.
Discharge Planning Progress Update	30/09/2024	Policy Review	R2 - The Health Board should ensure the revised discharge policy is updated on the Health Board's website.	Ms Diane Walker	30/06/2025	Amber	Overdue			AW Organisational Response - We have a plan in place to ensure the policy is updated by April 2025 when we will then add to Health Board website.
Urgent and Emergency Care: Arrangements for Managing Demand	31/03/2025	Signposting patients to the right services - To ensure that patients receive the urgent and emergency care that is most appropriate to their needs, the Health Board should liaise with Liais and other patient representative groups as appropriate to help identify where current patient information and signposting arrangements need strengthening	R2 - As a Health Board, we work closely with Liais and regularly seek their advice and support to identify areas for improvement. We will take this recommendation forward as an action. Liais also independently work around our clinical areas and engage with patients directly to gather feedback. In terms of strengthening signposting, we have made significant progress with the creation of a Single Point of Access for all urgent primary carerelated issues. This development follows the merger of CAV24/7 with our UPCC programme, where CAV24/7 clinicians now serve as clinical leads for the UPCC models. This integration has enabled us to establish a seamless referral system, available both during and outside of regular hours, seven days a week, 24 hours a day. These services are already interconnected with our Medical and Surgical SDECs, Safe@home, and Community Resource Teams. ED Triage nurses also have access to the UPCC system via an agreed access pathway, so all selfpresenting patients to	Mrs Rachel Thomas	30/06/2025	Amber	Overdue			
Urgent and Emergency Care: Flow out of Hospital - CAV Region	30/09/2024	Improving compliance with policies and guidance	R3 - The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of the discharge policy and associated training programmes.	Ms Diane Walker	30/06/2025	Amber	Overdue			AW Organisational Response - The Health Board will complete a baseline using the ward-based audit tool, Tendable, prior to adoption of the new policy and then review monthly to assess impact.

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Discharge Planning Progress Update	30/09/2024	Policy Review	R3 - The Health Board should explore developing an e-learning course for discharge planning which ward staff may find more accessible.	Ms Diane Walker	30/06/2025	Amber	Overdue			AW Organisational Response - i. The Health Board discharge learning lead will explore the feasibility and opportunity of an elearning course. This was previously considered prior to COVID-19 but this was not taken forward. ii. Face-to-face practice-based learning is already in place (see R1)	
Urgent and Emergency Care: Flow out of Hospital - CAV Region	30/09/2024	Improving the quality of information - the Health Board should improve record keeping by:	R4.1 - ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.	Ms Diane Walker	30/06/2025	Amber	Overdue			AW Organisational Response - This is being incorporated into the rolling programme of education for ward teams. In addition, there is a pilot underway in which a discharge booklet is being trialled on the winter ward in UHL to support clear documentation of discharge processes in patient case notes.	
Urgent and Emergency Care: Flow out of Hospital - CAV Region	30/09/2024	Improving the quality of information - the Health Board should improve record keeping by:	R4.2 - establishing a programme of case-note audits focused on the quality of record keeping.	Ms Diane Walker	30/06/2025	Amber	Overdue			AW Organisational Response - The Health Board will assess the best tools and process for auditing record keeping and, if appropriate, roll this out with ongoing training and audit cycles.	
Urgent and Emergency Care: Arrangements for Managing Demand	31/03/2025	Directory of Services - To ensure health and care staff are able to adequately signpost and refer people to the right urgent and emergency care services, the Health Board should: 4.1. Ensure the WAST Directory of Services contains the most up to date information on urgent and emergency care services; 4.2. Ensure the WAST Directory of Services includes information on relevant community based and third sector services; 4.3. Establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task	R4 - We acknowledge the potential for greater collaboration with WAST to review and enhance the Directories of Service. Our goal is to work closely with WAST colleagues to review the existing service directories and create a plan to ensure they are regularly maintained and kept up to date.	Mrs Claire Main	30/06/2025	Amber	Partially complete (Overdue)			These discussions have commenced but are part of the wider work with WAST/ PCIC and secondary care.	
Urgent and Emergency Care: Arrangements for Managing Demand	31/03/2025	Patient feedback - To ensure it is using patient feedback to understand and improve access to urgent and emergency services, the Health Board should: 5.1 Ensure surveys ask respondents about the effectiveness of alternative clinical pathways; 5.2 Work to increase response rates; and 5.3 Clearly respond to findings within future plans for urgent and emergency care services	R5 - The Health Board has created a patient feedback framework that covers all areas of care, both clinical and non-clinical. This includes the care environment, staff attitude and communication, teamwork, access to services, involvement in treatment decisions, and our ability to respond promptly and resolve issues. We use an electronic platform called CIVICA to collect feedback, and a QR code is available within patient waiting areas throughout the Health Board. This includes areas such as SDEC, UPCC, and Safe@Home, which serve as alternatives to the Emergency Department. Subsequently, feedback is shared with the Senior Team for each of the areas, for review and to inform future improvement planning. Feedback is utilised in our improvement plans within ED. There is however room to strengthen the review process in some areas, to ensure patients' feedback is being acted upon and used to implement changes. We will	Mrs Barbara Davies	30/06/2025	Amber	Partially complete (Overdue)			Within one of the Safe at Home service, one of the urgent care services delivered within Primary, Community and Intermediate Care (PCIC), specific patient feedback is captured at source and used to inform continuous improvements to the service provided to patients. The questions have been designed alongside the RPB questionnaire requirements. There is the option for patients +/- their family or carer to complete either a paper-based or digital (MS forms) patient feedback form. Feedback is reviewed regularly with reasonable and appropriate adjustments made to the service based on patient/family recommendations. The feedback form is confidential, however provides the patient/family member an option to provide a name and phone number if they would like to discuss any concerns with the team. Other sources of patient feedback received within PCIC are through the CIVICA feedback platform, the UHB enquiries process and the concerns	

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Review of Cost Savings Arrangements CAVUHB	16/01/2025	The Health Board should strengthen its arrangements for communicating its cost savings plans to staff.	The Health Board should strengthen its arrangements for communicating its cost savings plans to staff.	Andrew Gough	30/06/2025	Amber	Overdue				07.01.2025 - The UHB engages its staff through multiple communication points, in the context of the financial outlook and the need to identify and deliver Costs Reduction Programmes. The UHB seeks will seek to ensure that these initiatives are continued and strengthened and the need for increased focus is communicated clearly to all staff members. <ul style="list-style-type: none"> • Financial Sustainability Communications Working Group • Corporate SharePoint page and internal communications • Financial Sustainability – You Said, We Did, communications • Staff emails shared on key internal communications messages relating to Financial Sustainability • Communications support to individual portfolios in Medicines management, Workforce and Procurement • All Staff Engagement through 'Ask Suzanne' • Viva Engage • Local Partnership Forum • Clinical Board Executive Reviews In addition to these UHB/Corporate	20250903133700_financialsustainabilitysh arepointpage.docx
Tackling the Planned Care Challenges	31/05/2025	Monitoring impact of additional funding - R6 The Health Board should strengthen its reporting to Board on the direct impact of the additional Welsh Government planned care funding. (Paragraph 25)	This is reported up to Planned Care Portfolio Board with a quarterly update to the Health Board's Senior Leadership Board, and onwards to Board. Specific reference to the additional WG funding will be made at the end of Q2 reporting period	Catherine Wood	30/09/2025	Red	Overdue					
Tackling the Planned Care Challenges	31/05/2025	Efficiency and productivity - R7 The Health Board should: 7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. (Exhibit 6) 7.2 Develop and implement a plan to address high outpatient 'Did not attend's'. (Exhibit 6) 7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. (Exhibit 6) 7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. (Exhibit 6) 7.5 Increase Day Surgery rates to the GIRFT level of 85%. (Exhibit 6) 7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90%	7.2 Through the Outpatient Implementation Group, there is a plan to address high DNAs. This includes improving processes to address data quality and setting clear productivity guidance for the outcoming and "cashing up" of clinics. NHS Executive have issued a directive for all high DNA clinics to be routinely overbooked, work on which has commenced in Orthopaedics and Ophthalmology	Catherine Wood	30/09/2025	Red	Overdue					

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Tackling the Planned Care Challenges	31/05/2025	<p>Efficiency and productivity - R7 The Health Board should:</p> <p>7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. (Exhibit 6)</p> <p>7.2 Develop and implement a plan to address high outpatient 'Did not attends'. (Exhibit 6)</p> <p>7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. (Exhibit 6)</p> <p>7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. (Exhibit 6)</p> <p>7.5 Increase Day Surgery rates to the GIRFT level of 85%. (Exhibit 6)</p> <p>7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90%</p>	<p>7.5 Currently at 69%. The organisation has a ready-made solution to increasing day surgery rates in the form of the Surgical Hub @Llandough. Workforce is currently the rate limiting factor to achieving 85% current indications suggest this will resolve by September</p>	Catherine Wood	30/09/2025	Red	Overdue				
Tackling the Planned Care Challenges	31/05/2025	<p>Efficiency and productivity - R7 The Health Board should:</p> <p>7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. (Exhibit 6)</p> <p>7.2 Develop and implement a plan to address high outpatient 'Did not attends'. (Exhibit 6)</p> <p>7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. (Exhibit 6)</p> <p>7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. (Exhibit 6)</p> <p>7.5 Increase Day Surgery rates to the GIRFT level of 85%. (Exhibit 6)</p> <p>7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90%</p>	<p>7.6 Plans are in place to aim for 90% compliance by September 2025, although there is risk attached to this. A team-based approach to job planning is encouraged and is applied in the majority of specialties across the Health Board.</p>	Catherine Wood	30/09/2025	Red	Overdue				

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Structured Assessment 2024	31/10/2024	Risk Management - The Health Board should refresh the Risk Management Strategy to ensure it includes new arrangements for recording and escalating operational risks.	This will follow the completed transfer of all registers to a single one on AMAT.	Miss Francesca Thomas	31/12/2025	Amber	In progress			<p>May 2025 - digital risk management project is underway and a focus on the pace of this work will be scrutinised in Clinical Board reviews from July 2025. The Risk Management Policy/Strategy will be refreshed accordingly once this process has been completed.</p> <p>Aug 2025 - Digital Risk Management Task & Finish group launched in July 2025. Implementation plan now being worked up with Clinical Boards & Corporate Teams to migrate all organisational risks into AMAT, starting with the Corporate Risk Register (CRR) (risks scored 20+). T&F will now meet monthly with the aim of all CRR migrated by end of October 2025 in readiness for a moderation at SLT in November 2025.</p> <p>Oct 2025 - refresh of Risk Management Strategy & Policy due Q4 / Q1 2026/27 following completion of all UHB risks migrating onto AMAT. This will also be audited by Internal Audit in Q4.</p>
Tackling the Planned Care Challenges	31/05/2025	<p>Planning - R1 The Health Board should:</p> <p>1.1 develop an up-to-date planned care improvement plan and road map that articulates the design and delivery of sustainable specialty services in the medium to longer term. (Exhibit 2)</p> <p>1.2 set out its projected costings against forecast demand over a 3-to-5-year term with realistic and challenging milestones based on reasonable planning assumptions. (Exhibit 2)</p>	<p>1.1 The Health Board has recently published a 10 year Clinical Services Strategy for Babies, Children & Young People Plan 2025. It is the aim of the Health Board to publish a similar long-term plan for planned care and unscheduled and emergency care. The Health Board recently refreshed its overall strategy, Shaping Our Future Wellbeing, which outlines our vision and strategic objectives for 2023-2035. Alongside that work is underway to articulate the Health Boards Clinical Services Plan, of which the medium to long term for planned care is an integral part.</p> <p>It must be recognised however, that the everevolving political context creates a dynamic planning environment with numerous shortterm plans regarding buy out of the backlogs etc, that make a backstop position on demand and capacity challenging to create for the longer term.</p>	Catherine Wood	31/03/2026	Red	In progress			
Tackling the Planned Care Challenges	31/05/2025	Risk management - R4 The Health Board should develop a planned care risk register that fully assesses and mitigates the key risks that inhibit short term improvement and longer-term service transformation. (Exhibit 3)	The delivery and accountability for delivery of the component parts of Planned Care sits within Clinical Boards and their Governance Structures. The Planned Care team need to ensure that Planned Care risks are referenced on Clinical Board risk registers.	Catherine Wood	31/03/2026	Red	In progress			

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Audit Wales - Audit of Accounts Report Addendum for 2022-23	01/08/2022	Weaknesses in network security vulnerability assessments: The Health Board should strengthen its assessment of network security vulnerability by: • completing regular external penetration testing on the network perimeter, including at least annually by an accredited third party; and • actively monitoring the internal network penetration testing to promptly identify and address any weakness.	The UHB is currently in the process of appointing a dedicated cyber team. Two positions have been filled and we are recruiting a further two posts. An externally performed penetration test is being scheduled for Q4 of 2022/23. Once the cyber posts are in place, we will be in a position to proactively use a number of cyber tools at our disposal. This includes: SIEM, which is currently operational and staff are in the process of being trained. Defender for Endpoint, currently in the process of being onboarded and, Nessus, operated by the server team but will be supported by the cyber department. We anticipate that all roles will be appointed to by Q3 of 2022/23.	Mr James Webb	31/03/2026	Red	Partially complete			June 2024 update: Cyber Security Lead appointed in May 2024. Whilst adhoc pen tests occur, we plan to work up a regular pen test schedule. November 2025 - cyber team is fully resourced and all positions fulfilled. routine monitoring of network tools are undertaken but PEN tests remain very adhoc due to the operational challenges and logistics of managing such a large estate. Some key infrastructure has been pen tested including Remote Desktop Services (RDS). This action is linked to the cyber resilience unit which is part of DHCW which is due to be issued shortly. ## Action date extended to 31 March 2026 to review pending outcome of CRU audit ## Head of IG now action lead
Review of Cost Savings Arrangements CAVUHB	16/01/2025	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.	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.	Andrew Gough	31/03/2026	Amber	In progress			07.01.2025 - Budget holders are aware of savings targets as these are discussed, shared and devolved through the planning and form part of rolling monthly meetings and accountability meetings such as the monthly Executive Performance Reviews and the Monthly Finance- Ops meeting. Accountability letters have previously been considered and not pursued. They will be considered again as part of the 2025-26 Financial plan Process.
Tackling the Planned Care Challenges	31/05/2025	Efficiency and productivity - R7 The Health Board should: 7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. (Exhibit 6) 7.2 Develop and implement a plan to address high outpatient 'Did not attends'. (Exhibit 6) 7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. (Exhibit 6) 7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. (Exhibit 6) 7.5 Increase Day Surgery rates to the GIRFT level of 85%. (Exhibit 6) 7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90%	7.1 GIRFT recommendations, recommendations from the MAG report and NHS Executive's Enabling Actions for Planned Care are essentially the same framework of productivity, efficiency and grip and control of operational processes in acute services. This suite of measures now forms the basis of how the Health Board monitors progress and holds operational leaders to account. The Ophthalmology and General Surgery Directorates' recently submitted Maturity Matrix to their relevant national Clinical Implementation Group scored approximately 45% maturity against the identified measures, meaning that there is evidence of maturity in some areas, although there remains considerable work to do.	Adam Wright	31/03/2026	Red	In progress			

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Tackling the Planned Care Challenges	31/05/2025	<p>Efficiency and productivity - R7 The Health Board should:</p> <p>7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. (Exhibit 6)</p> <p>7.2 Develop and implement a plan to address high outpatient 'Did not attends'. (Exhibit 6)</p> <p>7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. (Exhibit 6)</p> <p>7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. (Exhibit 6)</p> <p>7.5 Increase Day Surgery rates to the GIRFT level of 85%. (Exhibit 6)</p> <p>7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90%</p>	<p>7.3 Short notice cancellations are reported daily to Executive level of the Health Board and the organisation's weekly 6-4-2 theatre booking and confirmation cycle seeks to address all aspects of theatre utilisation. The organisation does not yet have one single plan to address the full range of short notice cancellations. These reasons are many and range from equipment failure, unplanned staff availability and short-term sickness of patients. There are many preventable aspects of these reasons, and the expectation is that a Theatre Improvement Programme, as directed in the MAG review, and following an internal review, will focus on this.</p>	Catherine Wood	31/03/2026	Red	In progress				
Tackling the Planned Care Challenges	31/05/2025	<p>Efficiency and productivity - R7 The Health Board should:</p> <p>7.1 Ensure timely completion of all recommendations arising from Getting It Right First Time (GIRFT) reviews and accelerate progress in ophthalmology and general surgery services. (Exhibit 6)</p> <p>7.2 Develop and implement a plan to address high outpatient 'Did not attends'. (Exhibit 6)</p> <p>7.3 Develop and implement a plan to address the full range of causes of short notice surgical cancellations. (Exhibit 6)</p> <p>7.4 Develop and implement a plan to improve theatre utilisation rates across all core specialties, with realistic improvement trajectories, with the aim of achieving the GIRFT recommended level of 85% across most specialties. (Exhibit 6)</p> <p>7.5 Increase Day Surgery rates to the GIRFT level of 85%. (Exhibit 6)</p> <p>7.6 Ensure that the approach to consultant job planning focusses on maximising productivity and uses team-based approaches to help plan the future shape of services to meet the Welsh Government requirement that 90%</p>	<p>7.4 Short notice cancellations are reported daily to Executive level of the Health Board and the organisation's weekly 6-4-2 theatre booking and confirmation cycle seeks to address all aspects of theatre utilisation. The organisation does not yet have one single plan to address the full range of short notice cancellations. These reasons are many and range from equipment failure, unplanned staff availability and short-term sickness of patients. There are many preventable aspects of these reasons, and the expectation is that a Theatre Improvement Programme, as directed in the MAG review, and following an internal review, will focus on this.</p>	Catherine Wood	31/03/2026	Red	In progress				

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Tackling the Planned Care Challenges	31/05/2025	Promote, Prevent and Prepare for Planned Care Policy - R8 The Health Board should complete its implementation of the single point of contact for people to access information and support following referral to specialist secondary care. (Exhibit 7)	The Health Board's single point of contact service is the Waiting Well Support Service. As issued by Welsh Government in its Delivery Plan, new specialties and pathways are being brought into scope for the team in stages, with two additional specialties being added this month. As the Health Board does not have a unified patient administration system, the onboarding of specialties requires processes for lists of patients to be agreed and time built in for these to be uploaded and available digitally. This can be achieved and the team are happy to broaden their scope, and are focussing on the pathways and specialties in order of relevance, need and benefits to be realised. Executive Director of Therapies, Health Sciences and Community Development. The service is funded by Welsh Government until the 31st March 2026, meaning that a sustainability plan for ongoing support of this team is required by Q4 of this financial year.	Ms Joanna North	31/03/2026	Red	In progress	Currently the main risks are a lack of engagement from staff and insufficient funding to cover unfunded/temporarily funded posts.	As outlined in risks section above.	20/10/2026: the Operations team is supporting a programme of work which will consolidate three disparate teams, including the Waiting Well Support Service, into one team that will provide an optimisation offer to more patients. This will include cohorts of benign patients that at present do not have an offer of optimisation or single point of contact. This piece of work is being undertaken within a programme governance structure, with a recommendation of a new clinical pathway and new staffing model to be delivered by the end of Q3 this year.
Audit Wales - Audit of Accounts Report Addendum for 2022-23	01/08/2022	Progress against previous years' recommendations: The quality of some of the Health Board's underlying working papers requires further improvement 1. 2019-20: The Health Board should review and simplify its supporting records for certain areas of its annual financial statements, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand how some of the documentation affects our audit. 2. 2020-21: The Health Board should replace its unsupported Windows 2008 servers and W7 devices. 3. 2020-21: The Health Board should update and test its IT Disaster Recovery Plan (DRP) to gain assurance that IT systems can be restored if needed. 4. 2020-21: The Health Board should update its IT change-control policy and procedure. 5. 2020-21: The Health Board should evaluate and consider upgrading its IT1	1. The Health Board improved some of its processes and records for 2021-22 and we understand that it plans more improvements for 2022-23. We will continue to liaise with the finance team on the improvements. 2. The Health Board has an ongoing programme in place to replace or upgrade all affected devices. 3. The Health Board is reviewing and updating its IT DRP as part of a programme to refresh its IT security documentation. 4. The Health Board is updating its change control policy as part of its new helpdesk system. 5. The Health Board is currently reviewing its data centre rooms and is considering whether to decommission some of them.	Mr Andrew Partridge	31/03/2026	Red	Partially complete			1. Ref - Financial Accounts Issues - Part of 2022-23 Annual Accounts Processes. A Review process has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines. Update Nov 25 - every year Finance work with AW to review and improve how information is provided to audit. This recommendation relates to 19-20 which was the first year of conducting the finance audit in line with covid restrictions. 2. Work to replace Win7 devices is complete. work to replace 2008 server estate is on-going due to clinical service dependencies (additional controls have been put in place in the interim, pending migration and replacement). Nov 25 update - in the progress of replacing all windows 10 devices and legacy servers still exist. 3. The DR plan has been updated and is scheduled to be tested (Qtr4 22/23) Nov 25 update- Disaster recovery policy to be
Tackling the Planned Care Challenges	31/05/2025	Managing clinical risks associated with long waits - R9 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks and with long waits by: 9.1 Developing and implementing a more consistent approach for assessing the risk of harm to patients caused by long waits across specialties. (Exhibit 7); and 9.2 Developing a routine report to be presented at the Quality Committee that reports risks and actual incidences of harm resulting from delays in access to treatment across all clinical specialty areas of concern. (Exhibit 7)	9.1 The expansion of the Waiting Well Support Service could address this. Text invitations to contact the WWSS include a shortened HSQ which is triaged by the team and directs how the patient is contacted, by whom and what information is provided. The Health Board's new outpatient Validation programme, mandated by Welsh Government, includes invitation to complete a PROM. The scope of this validation is limited to first appointments only.	Mrs Alex Scott	31/03/2026	Red	In progress			

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Tackling the Planned Care Challenges	31/05/2025	Managing clinical risks associated with long waits - R9 The Health Board needs to strengthen its monitoring and reporting processes associated with managing clinical risks and with long waits by: 9.1 Developing and implementing a more consistent approach for assessing the risk of harm to patients caused by long waits across specialities. (Exhibit 7); and 9.2 Developing a routine report to be presented at the Quality Committee that reports risks and actual incidences of harm resulting from delays in access to treatment across all clinical speciality areas of concern. (Exhibit 7)	9.2 This requirement is being reviewed by the Assistant Director of Quality and Patient Safety which will include consideration of the following: • A review at pre-determined points during the patient pathway • Developing a way of cross-referencing long waiters with Datix recorded incidents • Reviews of expedited referrals • Reviews of validated upgrading of urgency	Mrs Alex Scott	31/03/2026	Red	In progress				20250916100820_qualitycommittee.msg
Review of Quality Governance Arrangements	01/06/2022	Risk Management - There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risk registers and the escalation and de-escalation of risk to/from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risk registers and introduce an appropriate process for the escalation and deescalation of risk to/from the Corporate Risk Register.	a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality, Safety and Experience Committee.	Mrs Alex Scott	31/03/2026	Amber	Partially complete			Update Sept 2025: the roll out of AMaT risk register module is underway, and it's use will be fully integrated into the clinical safety group ensuring oversight of clinical risk, mitigation and development of strategy through the clinical advisory groups. The clinical safety group is continuing to evolve and until this is fully embedded this action will remain as partially complete. clinical boards are currently migrating their risk registers onto AMaT and all corporate risks are now on AMaT ## Action date extended to March 2026 to re-review pending migration of all outstanding risk registers to AMAT from across the UHB ##	
Review of Quality Governance Arrangements	01/06/2022	Resources to support quality governance- Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.	2. Management of resources through the pandemic was challenging for the Infection Prevention and Control team. However as the pandemic reduces the focus for the IPC team is back on normal tier 1 IPC targets, we are now seeing the move back to normal business. Active recruitment also in place to recruit to outstanding vacancies.	Mrs Yvonne Hyde	31/03/2026	Red	In progress	With 3 nurse and a PA/Administrator vacancies there is insufficient support available within the IP&C team to provide adequate support to the Clinical Boards. The number of audits undertaken by the IP&C team will be reduced as will the number of education sessions provided	Admin post vacancy rejection is putting more strain on a team that are extremely busy and short staffed as the nurses are havint tp arrange and administrate their own meetings	The recruitment process is underway for a band 6 ACNS in IP&C, interviews will be held W/c 08/09/2025. However since that post became available 2 other members of the team have left leaving a band 6 and a band 7 ACNS and CNS posts vacant. A request to recruit is in progress The PA/Administrator for the IP&C team left the post in July, the vacancy request to replace her was rejected and had to be resubmitted 28/10/2025 UPDATE- The band 6 posts were initially rejected at scrutiny however the request was successful and both are in the recruitment process at present. The band 4 administrator post has been rejected twice at scrutiny panel, the request will be resubmitted as the lack of an administrator is putting extra strain on a team that is extremely short staffed due to the vacancies and sickness within the team ## Action date extended to review in March 2026 following progress of recruitment as outlined above ##	

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Review of Quality Governance Arrangements	01/06/2022	Resources to support quality governance- Resources within both the Corporate Patient Experience and Concerns Teams have reduced over the last three years and the COVID-19 pandemic has had a significant impact on the Infection Prevention and Control Team's capacity. At an operational level, the Surgery Clinical Board and Surgical Services Directorate have designated leads for many key aspects of quality and safety. However, they do not have protected time to fulfil several of these roles. The Health Board, therefore, should ensure there is sufficient resource and capacity to support quality governance at both corporate and operational levels.	4. The corporate team will work with the clinical board to identify QSE leads and responsibilities with an exercise to identify the time required to effectively deliver these agendas. This work will be undertaken over the next 2 months and all corporate clinical safety groups updated	Mrs Alex Scott	31/03/2026	Red	Partially complete			Update Sept 2025 - a paper has been completed determining the resources required from each CB to ensure adequate medical engagement in the quality agenda, this includes involvement in patient safety incidents, presentation in clinical advisory groups and specialist lead roles across the organisation. CBs will need to consider the implications of this paper on their resources and job planning. ## Action date extended to review in March 2026 ##
Urgent and Emergency Care: Arrangements for Managing Demand	31/03/2025	Referral Pathways - To improve access and utilisation of referrals for appropriate alternative urgent and emergency care services, the Health Board should work with key staff, including WAST to develop referral mechanisms that are clear, well-communicated and easily accessible.	R3 - Building on the progress made with the implementation of a robust Single Point of Access (highlighted above) our ambition is to further enhance these capabilities by developing a Navigation Centre and Digital Hub. This will enable consistent, quality-assured triage and facilitate onward referrals, ensuring that patients receive the right care quickly and safely, regardless of where they present. This will continue to interconnect with our SDEC's, Safe@Home, and Community Response Team. WAST, as well as other stakeholders will also be considered as part of this work. The Health Board has also implemented Community and Health Pathways to assist clinicians by providing access to a range of locally agreed pathways, which cover the assessment, management, and referral of patients. WAST currently have access to our MSDEC via an agreed pathway for a number of patient conditions, as well as telephone access via Consultant Connect to an	Mrs Claire Main	31/05/2026	Amber	In progress			
Tackling the Planned Care Challenges	31/05/2025	Planning - R1 The Health Board should: 1.1 develop an up-to-date planned care improvement plan and road map that articulates the design and delivery of sustainable specialty services in the medium to longer term. (Exhibit 2) 1.2 set out its projected costings against forecast demand over a 3-to-5-year term with realistic and challenging milestones based on reasonable planning assumptions. (Exhibit 2)	1.2 - The Health Board has submitted an Annual Plan for 25/26 as per the requirements specified by Welsh Government. Ministerial priorities are set on an annual basis as is the UHB allocation process. At present we do not have the capacity or capability to work on a window any further ahead than this. Although having a line of sight to the Capital and Revenue requirements to deliver a sustainable planned care offer is something which we aspire to and is likely to be reinvigorated over coming months through our clinical Services Planning process.	Adam Wright	31/03/2027	Red	In progress			

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Tackling the Planned Care Challenges	31/05/2025	Demand and capacity modelling - R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across its specialties to inform short-term service capacity planning and longer-term service design. This should also consider changes in population demand for planned care services. (Exhibit 2)	The Health Board has one centrally led team that undertakes demand and capacity modelling across all acute specialties. This is iterated quarterly and is the most mature demand and capacity process the organisation has instituted to date. Known changes in demand due to, for example, changes to screening programmes, are built into modelling, as well as seasonal changes. Whilst there is a robust demand and capacity process in place for RTT reportable specialties and the longest waiting patients, this approach has been driven by operational pragmatism, in concentrating on RTT first due to significant capacity constraints within the team to date precluding the ability to take a broader approach. The ambition to broaden this to all planned care specialties, and to triangulate workforce, core activity demand and finance is live, and a process is currently being designed to build this into the 2026/2027 planning cycle	Adam Wright	31/03/2027	Red	In progress				
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Regulatory Body	Lead Contact	Context	Frequency of inspection / review	How are recommendations / actions tracked?	Has AMAT been considered?	Escalation Route	Comments / Notes
CAV Food Hygiene	Geoff Walsh	Food safety is heavily regulated across the UHB. WG require a minimum food hygiene score of 4 - anything below a 4 has a mechanism for a report to be sent to WG.	Retail units inspected every 18 months across 12-13 units across the site. The UHB is exposed to 16-18 inspections every 18 months / 12 per year.	Held locally	AMAT been suggested and is being considered by the team	The Food Safety Assurance Manager reports monthly to the Director of Capital, Estates & Facilities with updates. It used to go through Health & Safety (H&S) Committee, and will now go through the Digital & Infrastructure (D&I) Committee.	
Llais	Angela Hughes / Sarah Tipping / Clinical Board					Information from Llais goes through the CEO and to Angela Hughes, who keeps all records.	The concerns / complaints where Llais are advocates are processed via the concerns team.
Health Inspectorate Wales (HIW)	Alexandra Scott / Suzie Cheesman	HIW inspects NHS services and regulates independent healthcare providers against a range of policies, regulations and guidance.	There are ad hoc unannounced inspections and announced inspections, in addition to national thematic reviews.	Local tracker maintained by Safety, Quality and Organisational Learning Team. AMaT used by Clinical Boards to log improvement plans and track actions.	AMaT is used to log HIW improvement plans and track progress with actions.	Executive oversight of all HIW responses and improvement plans. Regular reporting of HIW activity and progress with improvement plans through the Quality Committee.	HIW also review the care of persons who die in custody, on behalf of the Prisons and Probations Ombudsman. Where the death occurs within HMP Cardiff, the UHB may be involved as the healthcare provider. HIW also check compliance with the IRMER 2017 (2024) regulations. Lead will be Lesley Harris and they attend more regularly than ONR/NRW. Assurance reviewed via RPG.
Fire Service	Rob Warren / Ryan Paxford	South Wales Fire & Resue Service (SWFRS) are a statutory regulator with enforcement powers.	Regular inspections across the wider UHB throughout any financial year. The UHB is usually notified however, they have the authority to inspect unannounced.	Managed locally	Will consider using an audit tool going forward.	The tracker is brought to every other People & Culture (P&C) Committee	
Health Education and Improvement Wales (HEIW)	Karl Davis / Ceri Hill	HEIW are responsible for resident doctors in training posts. HEIW manages a Quality of Medical Training Risk Register and undertakes targeted visits to specialty areas identifying concerns. This forms UHB immediate recommendations and a detailed action plan that is time dependant and monitored by HEIW.	HEIW Visits are as triggered. Review is ongoing with revisits usually 6/12 Annual review of All Wales Risk Reports in line with General Medical Council (GMC) National Training Survey results	Tracked via HEIW All Wales Risk Reporting mechanisms and local UHB action planning processes	Currently in process of moving UHB action planing on AMAT	AMD used to present an annual report to Board. Now feeds through the Quality Committee. All reporting is through the Medical Director, AMD and CEO.	
Health & Safety Executive (HSE)	Rob Warren	The HSE are a statutory regulator with enforcement powers.	Ad-hoc interventions that are usually notified in advance however, they have the authority to inspect without notice.	Managed locally	Will consider using an audit tool going forward.	The tracker is brought to every other People & Culture (P&C) Committee. Any significant open issues are taken to every meeting.	
Information Commissioner's Office (ICO)	James Webb	Fairly rare - the UHB hasn't been audited since 2020	Ad-hoc and based on intelligence i.e high number of complaints received.	AMaT	Yes		
Joint Accreditation Committee ISCT-Europe & EBMT (JACIE)	Helen Luton / Catherine Twamley / Sarah Lloyd / Keith Wilson / Gareth Jenkins	JACIE is an international accreditation system for cellular therapy organisations. First inspection was in 2013, except for physical facilities in CAV site. Second in 2017, which went well, but even more disheartened by the physical facilities on CAV site. The physical facilities described in 2013 has been on the UHBs risk register since 2010.	Once every four years - due one in September 2025.				TBC

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JAG (Joint Advisory Group on Gastrointestinal Endoscopy)	Jesse Ayertey	The UHB are not compliant or accredited at present. JAG is a governance body for all endoscopy units. You can still perform endoscopy without JAG accreditation, but there is a financial benefit to having JAG, and an increment and funding with JAG. There is also the very strong governance structure to abide by in order to be accredited. The JAG standards are important for an endoscopy unit to function properly.	You need to do an initial JAG assessment for submission, and then you get pre-accredited ahead of a site visit. The inspectors inspect the unit and interview people. Once accredited, there is an annual assessment and a five year assessment.	JAG action plan managed locally on a spreadsheet.		Governance and reporting sit with Medicine CB, overseen by Jesse Ayertey.	The UHB is not accredited at present.
Medicines and Healthcare products Regulatory Agency (MHRA)	Tim Banner / Sarah Martin	The MHRA allows them to manufacture unlicensed medications for use in the UHB and to sell to other NHS units and community pharmacies across the UK and beyond.	They are behind schedule, potentially have only had 2 inspections over the last 5 years. Probably due an inspection sooner rather than later.	Inspections are followed up with a report 2 weeks from the inspection, and the UHB has to respond within 3-4 weeks with an action plan and timeframes. Tracking feeds into the Regulatory Compliance Groups where they review progress against the actions. Tracked through ILAP system.	n/a	Tracking feeds into the Regulatory Compliance Groups.	Inspections are followed up with a report 2 weeks from the inspection, and the UHB has to respond within 3-4 weeks with an action plan and timeframes.
Natural Resources Wales	Geoff Walsh / Lesley Harris / Rachel Bidder	Mandatory - relates to new Welsh Government (WG) guidance around waste and the segregation of waste. There will be fines if non-compliant. Environmental Permitting Regulations (EPR2016) - Rachel Bidder & Emily Seymour is the appointed Radioactive Waste Adviser (RWA) for the UHB. Our next inspection is on the 17/11/2025 at UHW. NRW will check our compliance with EPR2016.	Previous inspection at UHW was 30/4/2019. Previous inspection at UHL was in 2020. Inspections are very much ad-hoc.	Plan to use AMAT	Yes, this is our preference	Assurance is reviewed via the Radiation Protection Group (RPG) which is chaired by Lesley Harris. Will feed through the Digital & Infrastructure Committee for assurance.	
Office for Nuclear Regulation (ONR)	Lesley Harris / Rachel Bidder	ONR checks compliance against ("Accord europeen relative au transport international des marchandises dangereuses par route" (ADR) /Carriage of Dangerous Goods regulations (UHW/UHL involvement)	Previous inspection for CAVUHB was on the 7/8	Plan to use AMAT	Yes, this is our preference	Assurance is reviewed via the Radiation Protection Group (RPG) which is chaired by Lesley Harris.	
Primary Immunology Service							
Research and Development	Sarah Martin	MHRA is the main regulator, and only drug studies got inspected.	The last sponsored inspection was 12 years ago, but could happen soon.		Happy to consider using AMAT in the future.		
The United Kingdom Accreditation Service (UKAS) / All Wales Genomics Laboratory	Clive Morgan / Laura Ferguson	Not a legal requirement but best practice. Accredited to ISO15189 standards by UKAS. Voluntary suspension of accreditation in 2024 due to relocation of laboratory. Reapplication process to commence in 2026	UKAS accreditation cycle is over a four-year period, with three annual surveillance assessments and a final reassessment to renew accreditation. Following reapplication to UKAS we will return to the assessment cycle.	Monitored within our Quality Management System (QMS) system Q-Pulse, with outputs fed into the UKAS portal.	We are moving Risk Assessments to AMAT. External Assessments to remain in our QMS.	Internally presented through monthly Quality meetings. Governance via All Wales Medical Genomics Service (AWMGS) Senior Leadership Team (SLT), direct link to executive team.	
Welsh Water	Geoff Walsh		They are occasional inspections, only when there is an issue.				

Welsh Scientific Advisory Committee (WSAC)	Lorraine Lewis	All-Wales Quality Standards external audits – feeds down into ASSAG (Audiology Specialist Standing Advisory Group). This has all UHB representatives in this collaboration.	5 sets of quality standards which are assessed individually on a 3 years cycle for Auditory Implant Services, Adult Rehabilitation, Children's Hearing Services, Tinnitus Services, Vestibular Services	Tracked locally at present	Agreed with Mike Murphy to move on to AMAT for cycle starting in June 2026; next audit is Adult Rehab in November 2025 which too soon to move to AMAT. Tinnitus and Vestibular to be audited June 2026	Presented to Surgery Clinical Board QSE meetings; last presented in July 2025	
West Midlands QRS							
Coroner	Angela Hughes	We provide information for Coroners requests and records etc		Datix		Quality Committee	
Inquest	Angela Hughes	All Inquests are managed through the patient experience team		Datix		Quality Committee	Reviewed annually by the Welsh Risk Pool we develop lesson learning statement and these feed into redress cases and LFER'S where appropriate
Claims CN and PI	Angela Hughes	We manage claims in accordance with the civil procedural rules and support from WHLS where required	Annual Inspection by Welsh Risk Pool	Amat for overall improvement plan from inspection		Quality Committee	Internal audit undertake a financial compliance Audit
Concerns - Putting Things Right	Angela Hughes	All complaints and Redress cases are managed via the Patient Experience team	Annual Inspection by Welsh Risk Pool	Amat and Datix		Quality Committee	Reviewed annually by the Welsh Risk Pool we develop improvement plan where needed
Estyn							
Home Office for Controlled Drugs	Tim Banner	The UHB hold controlled drugs licenses	There is an annual review that may result in an inspection.				
Cyber Resilience Unit (CRU)	James Webb	Audit under Network and Information Systems (NIS) Directive requirements. Welsh Government (WG) are the competent authority.	Annually	Locally	Yes, but the reports from the CRU are difficult to understand/use		

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Report Title:	Counter Fraud Progress Report			Agenda Item no.	4.1
Meeting:	Audit & Assurance Committee	Public	x	Meeting Date:	18/11/2025
		Private			
Status <i>(please tick one only):</i>	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 Board/Committee:

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

Appendices that accompany this covering report:

4.1a COUNTER FRAUD PROGRESS REPORT - CAVUHB PUBLIC P3

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
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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	

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Caerdydd a'r Fro
Cardiff and Vale
University Health Board

NHS WALES

Counter Fraud Progress Report

15/08/2025 – 03/11/2025

Public

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12/11/2025 09:16:12
HENRY BALES
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the 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 15/08/2025 – 03/11/2025.

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 \(sharepoint.com\)](#)



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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 one of these sessions has taken place with ‘mini’ talks being given to all in attendance (circa 65 members of staff).

A talk was given to five individuals on the graduate scheme within the organisation.

A talk was given at the PCIC GP Education (CPET) session to around 80 individuals from GP practices in the area to raise awareness of frauds that could happen in practices.

A departmental talk was given to the finance directorate capturing approximately 60 members of the finance team.

Newsletter – A counter fraud newsletter was created, circulated and publicised in June. You can view the newsletter by following this link [September 2025 - Counter Fraud Newsletter](#) (you will need to log in to your NHS Microsoft account to view).

Prevention

IBURN/Alerts (intelligence bulletins) – (2)

Intelligence received regarding incidents in wider NHS of fraudulent requests for gift cards. No issues identified in the organisation. Alert created and circulated.

Report of a potential phishing scam relating to a system that may be used by the organisation. No issues identified however alert created and circulated to relevant individuals.

System Weakness Reports – (1)

Risk identified regarding training for ‘document identification’, this has been shared with relevant departments and training has been organised and completed.

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National Fraud Initiative

Progress for NFI reviews continues a summary of cleared matches is shown below. Work is underway to cover all of the high risk matches and percentage of remaining matches, and this will be completed before the end of the NFI exercise.

Report Type	Total No. of Matches	No. Cleared No issues	No. Promoted to Investigation
Payroll to Payroll - NI	4	3	0
Payroll to Payroll – NI (External)	198	58	0
Payroll to Payroll – Email Address	3	3	0
Payroll to Payroll – Phone number	3	3	0
Payroll to Pension	122	0	0
Payroll to Creditors	95	0	0
Payroll to Companies House (Director)	31	0	0

Referrals

During this reporting period there have been a total of 28 referrals made to the team. 4 of these referrals have been promoted to investigations (detailed in next section). 3 referrals remain in initial assessment stage. The remaining referrals have all been closed.

Investigations

During this period there have been 4 investigations commenced by the counter fraud team. There have been 6 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.

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Investigations opened in the period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/25/02596	Working elsewhere in contracted hours	03/09/2025	30/09/2025	No fraud found
INV/25/02716	Prescription Fraud	15/09/2025		
INV/25/02690	Overseas Patient	12/09/2025	26/09/2025	No fraud found
INV/25/02805	Working elsewhere whilst sick	25/09/2025		

Investigations Closed in this period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/00825	Salary Overpayment for Sick Pay	CARRIED OVER - 02/05/2023	21/08/2025	Civil recovery
INV/25/00121	Accessing records	CARRIED OVER - 15/01/2025	10/10/2025	Internal disciplinary
INV/25/01455	Timesheet	23/05/2025	15/09/2025	Internal disciplinary
INV/25/02415	Working Elsewhere whilst sick / dual employment	12/08/2025	15/09/2025	No fraud found
INV/25/02596	Working elsewhere in contracted hours	03/09/2025	30/09/2025	No fraud found
INV/25/02690	Overseas Patient	12/09/2025	26/09/2025	No fraud Found

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Investigations that remain open

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/01634	Salary Sacrifice Vehicle - Payments not made	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/24/03059	Theft of Medication	CARRIED OVER - 29/11/2024		
INV/25/00286	Taking study leave not entitled to	CARRIED OVER - 03/02/2025		
INV/25/00720	Theft of Cash and Drugs	CARRIED OVER - 11/03/2025		
INV/25/01599	Working whilst sick	05/06/2025		
INV/25/02172	Working elsewhere whilst sick	14/07/2025		
INV/25/02716	Prescription Fraud	15/09/2025		
INV/25/02805	Working elsewhere whilst sick	25/09/2025		

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3. Significant Salary Overpayments

There have been two significant salary overpayments reported for this period. Both of these have been reviewed by the counter fraud team and neither 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.

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