AUDIT AND ASSURANCE COMMITTEE

Tuesday 19 May 2026 via MS Teams (click to join)

AGENDA

09:00	**1. Preliminaries**	
1.1	Welcome & Introductions	David Edwards
1.2	Declarations of Interest	David Edwards
1.3	Minutes of the Committee meeting held: 03.02.2026	David Edwards
1.4	Actions following meeting held: 03.02.2026	David Edwards
1.5	Any Other Urgent Business	David Edwards
09:10	**2. Items for Review & Assurance**	
09:10 2.1 20 mins	Internal Audit Progress Report including: • *Occupational Health Services (substantial)* • *Risk Management & Board Assurance Framework (reasonable)* • *Neurodevelopmental Services – Children (reasonable)* • *Rhydlafar Development (reasonable)* • *Wellbeing Hub at Park View (reasonable)* • *Nurse Staffing Levels (reasonable)* • *Clinical Board Adherence to the Managing Attendance at Work Policy (limited)* • *Staff Overpayments (limited)* • *Neurodevelopmental Services – Adults (limited)* • *Digital Literacy (advisory)* • *Medical Staff Deployment (advisory)* • *Alcohol Standards Follow Up (advisory)* • *Decarbonisation Follow Up (advisory)* ***All final reports can be found in the supporting documents folder.***	Ian Virgil Katrina Griffiths Lianne Morse Samuel Barrett
09:30 2.2 10 mins	Internal Audit Draft Annual Plan	Ian Virgil
09:40 2.3 15 mins	Audit Wales Update including: *Audit Plan 2026*	Audit Wales
09:55 2.4 10 mins	Risk Management The Corporate Risk Register (appendix 1) can be located in the supporting documents folder.	Matt Phillips
10:05 2.5 10 mins	Policy Management	Matt Phillips
10:15 2.6	Procurement Compliance Report	Catherine Phillips

10 mins		
10:25	**3. Items for Approval/Ratification**	
3.1 5 mins	Committee Annual Report	Matt Phillips
3.2 5 mins	Losses and Special Payments Panel Report 2025-2026	Catherine Phillips
10:35	**4. Items for Noting & Information**	
4.1 -	Annual Declarations of Interest Report	Matt Phillips
4.2 -	Counter Fraud 1) *Progress Update* 2) *Counter Fraud Annual Plan 2026/27* 3) *Counter Fraud Annual Report 2025/26*	Henry Bales
10:35	**5. Agenda for Private Audit and Assurance Committee**	
	i. *Approval of Minutes* ii. *Counter Fraud Progress Update (Confidential – ongoing investigations)* iii. *Draft Head of Internal Audit Opinion* iv. *Draft Annual Report & Accounts* v. *Corporate Governance Code Self-Assessment* vi. *Audit Wales Annual Accounts Update* vii. *People & Culture Assurance Report*	
10:35	**6. Any Other Business**	
10:35	**7. Review & Final Closure**	
7.1	Items to defer to the Board / Committees & Review of Future Actions	David Edwards
7.2	Date and Time of the next Committee meeting: Tuesday 23 June 2026 (Special Meeting) via MS Teams.	David Edwards
7.3	**5-minute break prior to Private Session**	

Minutes of the Public Audit & Assurance Committee Meeting
Held On 3 February 2026 at 9:00am
Via MS Teams

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

Item No	Agenda Item	Action
A&A 26/02/1.1	**Welcome, Introductions & Apologies for absence (click to view)** David Edwards (DE), the Independent Member for ICT and Committee Chair welcomed everyone to the meeting and apologies for absence were received.	
A&A 26/02/1.2	**Declarations of Interest (click to view)** **The Committee resolved that:** a) No Declarations of Interest were noted.	
A&A 26/02/1.3	**Minutes of the Committee meeting held 02.09.2025 (click to view)** The Minutes of the Meeting Held on the 02.09.2025 were received. **The Committee resolved that:** a) The draft minutes of the meetings held on 02.09.2025 were deemed to be a true and accurate record of the meeting	
A&A 26/02/1.4	**Actions following meeting held: 02.09.2025 (click to view)** The Actions were received. **The Committee resolved that:** a) The Actions were noted.	

A&A 26/02/2.1	**Internal Audit Progress Report: (click to view)** The Committee received the Internal Audit Progress Report, presented by Ian Virgil (IV), Head of Internal Audit and supported by Lucy Jugessur (LJ), Internal Audit Manager which provided an update on delivery of the 2025–26 Internal Audit Plan and associated activity. IV reported that four audits originally scheduled for reporting at the meeting had been delayed and were therefore not finalised in time. He explained that the delays reflected a combination of capacity and scheduling challenges on both the Health Board and Internal Audit sides and highlighted the Wellbeing Hub at Park View audit, noting that delays had arisen due to difficulties in securing meetings with relevant teams. He confirmed that a meeting had now taken place and that a further meeting with Geoff Walsh (GW), Director of Capital & Estates was scheduled, which would enable the audit to progress. He also confirmed that delays affecting the Managing Attendance at Work audit had been resolved, with information now received and fieldwork nearing completion. The Committee was advised that, notwithstanding those delays, eight audits had been finalised and were ready for presentation. IV confirmed that the assurance ratings for the audits were set out in the report and that the executive summaries would be presented later in the agenda. He reported that the 2025–26 Internal Audit Plan comprised of 35 audits, of which 11 had been completed to final report, two were at draft stage, seven were in progress, and the remainder were at planning stage. He confirmed that all audits had agreed briefs and were resourced for delivery. While acknowledging that the latter part of the year would be challenging, he provided assurance that sufficient audit work would be completed to inform the annual internal audit opinion. Rhian Thomas (RT), Independent Member – Capital & Estates asked whether Internal Audit required not only a sufficient number of completed audits, but also sufficient breadth of coverage across the organisation, in order to form the annual opinion, and whether that was being achieved. IV confirmed that the Internal Audit Plan was structured around eight audit domains, covering key areas across the Health Board. He advised that audits were being delivered across each of these domains and that Internal Audit were confident that there would be sufficient breadth of completed work to support the annual opinion. He confirmed that this would continue to be monitored and that priorities could be adjusted if required. Kirsty Williams (KW), Chair of the University Health Board asked whether Internal Audit had any observations about the effectiveness of arrangements for ensuring that audit	

findings were appropriately shared and utilised across other committees, to support wider organisational assurance and improvement.

IV confirmed that there was an established process whereby relevant Internal Audit reports were referred to other committees, such as the Quality Committee and Finance Committee, where appropriate. He advised that this process was operating effectively and that Internal Audit was comfortable with the current arrangements.

Executive colleagues supported IV's response by providing examples of recent Internal Audit reports being considered by other committees and used to inform forward planning and quality reporting.

DE noted that Internal Audit delivery continued to be weighted towards the latter part of the financial year and highlighted the risks associated with that, particularly where delays arose that were outside Internal Audit's control. He asked that consideration be given to how future audit plans could be de-risked avoiding excessive year-end concentration.

IV confirmed that the issue would be considered as part of the development of the 2026–27 Internal Audit Plan, including how audit delivery could be more evenly profiled across the year.

He confirmed that the draft plan would be presented to the Committee for approval at its May meeting, at which point further assurance could be provided.

The Committee were presented with the conclusions and assurance ratings for audits finalised within the current reporting period which included:

- **GMS Unified Contract Assurance Framework -** Substantial assurance, only one medium finding (visit reports not being issued, now to be addressed).

- **Additional Learning Needs (ALN) Legislation -** Reasonable assurance, but with two high and eight medium actions. Key issues raised included inconsistent use of statutory monitoring reports, low attendance at operational group meetings, lack of overarching governance policy, and a paused KPI dashboard.

KW expressed concern that "reasonable" assurance felt insufficient given legal compliance risks and rising demand. She asked how the rating was determined and how the organisation would monitor that risk.

LJ explained that the rating was borderline between reasonable and limited, with Welsh Government review pending. She suggested a follow-up audit may be needed.

Matt Phillips (MP), Director of Corporate Governance **proposed bringing the ALN work to the Quality Committee for further scrutiny, emphasising the need for better exposure and stakeholder engagement.**

- **Medical Equipment and Devices -** Reasonable assurance, with two high and two medium actions. Issues: overdue planned maintenance, policy overdue for review, and inaccurate records.

RT questioned the sustainability of current assurance given overdue maintenance. LJ confirmed that management had acknowledged the need for recruitment to address that.

	• **Standards of Business Conduct -** Reasonable assurance, two medium findings. Communication to staff on declarations of interest and gifts/hospitality was lacking, though independent members were well-informed. DE asked if authority levels and roles were considered. LJ and MP confirmed that focus was on band 7+ and clinicians, with statistics reviewed at Clinical Board level. • **Children and Women's Clinical Board – Governance and Financial Arrangements -** Reasonable assurance, one high (outdated or missing terms of reference for groups) and one medium (minutes/action plans missing). KW observed recurring governance and financial management issues across clinical boards, questioning if that was systemic. LJ confirmed similar findings in other health Boards. Catherine Phillips (CP), Executive Director of Finance discussed the need for immediate leadership and management development, not just waiting for organisational redesign. Rachel Gidman (RG), Executive Director of People & Culture confirmed that work had started with general managers and practical tools would be actioned. • **Financial Sustainability -** Reasonable assurance, one high (delays in shift requests), two medium (high reliance on bank staff, lack of unified rostering system, limited PMO impact). RT raised the lack of a standard project management methodology. LJ clarified that the PMO was not fully resourced and accountability had returned to Clinical Boards. RG noted ongoing work to improve rostering transparency. • **Quality and Safety Governance (Advisory Review) -** Advisory review found established arrangements but some lacked clarity on escalation. It was noted that there were opportunities for improvement identified and an action plan would be brought back to a future meeting. • **Health Roster System Follow-Up -** Second follow-up (no assurance rating as per new standards). It was noted that of four outstanding actions, two were completed and two still required work. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report were considered b) The proposed adjustment to the 2025/26 plan was approved.	
A&A 26/02/2.2	**Audit Wales Update (click to view)** The Committee received an update from Urvisha Pere (UP), Audit Lead - Audit Wales, covering the Review of Eye Care Services, the Structured Assessment, and the 2025 Annual Audit Summary. UP advised that the reports had been circulated in advance and focused her presentation on the key findings and messages arising from the work.	

	She outlined the Audit Wales Review of Eye Care Services, covering leadership, ophthalmology performance, long waiting times and harm, and the effectiveness of regional arrangements. It was noted that regionally, the approach was seen as positive but was slow to deliver impact, with a focus on short-term capacity pressures (particularly cataracts) and complex decision-making arrangements. Locally, while the Health Board was prioritising its longest-waiting patients and had strengthened leadership and harm reporting processes, performance remained below national targets, increasing the risk of avoidable harm. Further long-term planning, productivity improvements and stronger Board-level oversight were required. The Committee was advised that five recommendations were made, with regional responses agreed and Health Board-specific responses were set out in the report. **Executive Response to the Eye Care Report:** Catherine Wood (CW), Deputy Chief Operating Officer attended the meeting to respond to the Eye Care report. She thanked Audit Wales for the review and advised that the recommendations were considered balanced and constructive. She acknowledged that demand and capacity challenges remained within eye care services but outlined actions taken since the review to improve sustainability. It was reported that pathway-by-pathway workforce and demand plans had been developed over a three-year planning horizon for key ophthalmology pathways, including cataracts, glaucoma and intravitreal therapies, representing significant progress since the time of the audit. CW also reported improvements in productivity and efficiency, noting that a dedicated cataract theatre had been opened at Llandough Hospital, resulting in a consistent increase in the number of cataract procedures undertaken per list, exceeding recommended benchmarks. She advised that further improvements were planned through the introduction of a dedicated glaucoma diagnostics clinic using a different skill mix, which would release consultant capacity. The Audit Wales recommendation were also addressed regarding risk registers, advising that ophthalmology risks were being reviewed dynamically and that, as a result of the improvements made, some risks had been downgraded. CW confirmed that ophthalmology risks no longer met the threshold for inclusion on the corporate risk register, as had been the case previously. **The Committee resolved that:** a) The Audit Wales Update was noted.	
A&A 26/02/2.3	**Audit Wales - 2025 Structured Assessment** The Audit Wales - 2025 Structured Assessment was received. UP reported that the assessment found that the Health Board had demonstrated an inclusive approach to developing its annual plan, supporting delivery of its long-term	

	strategy, and that progress was being made in clinical services planning and ward-level reporting. She advised that further work was required to strengthen delivery roadmaps for strategic portfolios and Committee oversight and noted that the Health Board continued to demonstrate a strong commitment to public transparency and engagement with patients and staff, and that significant Board turnover had been managed well. She highlighted, however, that the absence of an Independent Member for Finance presented a risk. UP also advised that opportunities remained to enhance the quality of Board and Committee papers, risk and performance management, and aspects of quality and safety monitoring and recommendation tracking. She confirmed that, despite strong financial governance processes, the Health Board's financial position remained extremely challenging and advised that ten recommendations had been made, with management responses included in the papers. MP thanked Audit Wales for the Structured Assessment and advised that the findings were considered fair. He confirmed that the recommendations would be tracked through the AMAT system and reported back to the Committee, including where actions aligned with other governance and assurance work. KW thanked Audit Wales for the assessment and advised that the findings aligned with her observations since joining the Board. She emphasised the importance of using the Structured Assessment as a tool to drive improvement, rather than simply noting the findings. **The Committee resolved that:** a) The contents of the report were noted.	
A&A 26/02/2.4	**Audit Wales - 2025 Annual Audit Summary** The Audit Wales - 2025 Annual Audit Summary was received. UP introduced the annual audit summary, which consolidated the main findings from the 2025 financial and performance audit work. She noted that all individual audit pieces in the report had already been reviewed by the Audit Committee and highlighted a new feature within the report: an overall conclusion and summary of recommendation themes based on the 2025 work. **The Committee resolved that:** a) The contents of the report were noted.	
A&A 26/02/2.5	**Procurement Compliance Report (click to view)** The Procurement Compliance Report was received. The report provided an update on procurement compliance activity, including breaches of Standing Financial Instructions (SFIs), non-compliant procurement activity, exemptions, and the use of Single Tender Actions (STAs). CP advised that the report had been updated since the previous meeting to reflect additional clarity and improvement actions and explained that the first section of the	

	report detailed breaches of SFIs that had occurred during the reporting period, with additional narrative included to explain the circumstances of each breach, the actions taken, and the current status. She noted that many breaches were identified at the point when an order was raised or a payment was attempted, at which stage procurement teams were able to intervene, provide advice, and ensure appropriate governance was applied. CP explained that further tables within the report related to non-compliant procurement activity, including exemptions and circumstances where it had not been possible to undertake full procurement processes. She emphasised that such cases did not indicate an absence of governance or procurement oversight, but rather reflected situations where full market testing could not reasonably be undertaken within required timescales or operational constraints. Turning to Single Tender Actions, CP advised that the report demonstrated continued progress in driving down non-compliant activity and reducing the number of STAs, including where claims were made that only a single supplier was available. She highlighted that this reflected ongoing work to strengthen procurement discipline and challenge assumptions where appropriate. RT welcomed the improvement actions identified within the report, and highlighted the development of the rapid response framework for emergency procurement requirements. She noted that a significant proportion of non-compliant procurement activity arose from urgent operational needs combined with lengthy procurement processes and commented that the introduction of a rapid response framework had the potential to be a “game-changer” in addressing that issue. She expressed interest in seeing how this framework progressed and acknowledged the effort being made to improve procurement compliance across the organisation. **The Committee resolved that:** a) The contents of the report were noted and approved/agreed.	
A&A 26/02/3.1	**Risk Management Policy** The Risk Management Policy was received. MP advised the Committee that the policy replaced a number of previous policies and procedures and had taken some time to finalise, reflecting the significant programme of work undertaken to develop and embed a risk module within the AMAT system. He explained that the work had positioned the Health Board as the first NHS organisation in the UK to implement such a system and advised that approximately 800 risks had now been transferred into AMAT, enabling the policy to function not only as a theoretical document but as a practical “how-to” guide for staff. MP explained that the policy had been deliberately written to be usable by staff at all levels and directed readers to a dedicated SharePoint site containing training materials and guidance.	

	He confirmed that the next phase of work would focus on fully embedding risk recording within AMAT and moderating risks through clinical directorates, Clinical Boards, the Senior Leadership Team, and ultimately to Board level where appropriate. RG commented on the importance of clearly articulating individual responsibilities within the policy and noted that it should not be assumed that staff understood their responsibilities in relation to risk management and emphasised the need for clarity, training and accountability alongside the policy. MP agreed and advised that responsibilities had been deliberately clarified and simplified within the policy. He explained that the policy was supported by a programme of task-and-finish groups, structured training, and bespoke support, which had been used both to develop the AMAT system and to build staff capability. He confirmed that this work would continue to ensure that staff across the organisation understood their roles and responsibilities in relation to risk. KW confirmed that she was content with the policy itself but queried how risk management would be brought to life in practice, particularly at Committee and Board level. She asked how risk information would be used to support decision-making rather than simply being presented as a standing agenda item. MP responded that embedding risk management from the "ground up" was a critical part of the approach and explained that, while risk reporting at Board level was important, the priority was ensuring that risks were being actively identified, scored and managed within services and directorates. He noted that some over-scoring of risks had been identified during the migration to AMAT and that moderation processes were being strengthened to address those. DE commented that risks existed at all levels of the organisation and asked how the Committee could gain assurance that the risk management framework was operating effectively on a day-to-day basis, not just at Board or Committee level. He highlighted the importance of understanding how risks identified at operational level were escalated appropriately through the organisation. MP acknowledged the point and advised that improving visibility of how risk management operated in practice was a key area of ongoing work. He explained that the consolidation of multiple local risk registers into AMAT would enable better organisational intelligence and reporting. He noted that the system would allow clearer tracking of how risks moved through governance levels and how they informed planning and decision-making. IV advised the Committee that Internal Audit had included a review of risk management and assurance arrangements within its audit plan for the year. He confirmed that this review would examine how the AMAT system was working in practice across a sample of areas and would provide the Committee with assurance on the effectiveness of risk management arrangements. **The Committee resolved that:** a) The Risk Management Policy was reviewed and approved.	
A&A 26/02/4.1	**Counter Fraud Progress Update**	

	The Counter Fraud Progress Update was received. **The Committee resolved that:** a) The Counter Fraud Progress Update was noted.	
A&A 26/02/5	**Agenda for Private Audit and Assurance Committee** *i. Counter Fraud Progress Update (Confidential – ongoing investigations)* *ii. People and Culture Assurance Report*	
A&A 26/02/6	**Any Other Business** No Other Business was discussed.	
A&A 26/02/7.1	**Items to be deferred to Board / Committee**	
A&A 26/02/7.2	**Date and time of next committee meeting** 19 May 2026 via MS Teams.	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update	Comments
AUDIT & ASSURANCE	Internal Audit Progress Report	A&A 26/02/2.1	Consider how future Internal Audit plans (specifically 2026–27) can be de-risked to avoid a heavy concentration of audits at the end of the year, recognising risks outside Audit's control (e.g. delays during the year).	Catherine Phillips	Ian Virgil	03/02/2026	19/05/2026	ON FORWARD PLAN	The 2026-27 plan will be coming to the May Audit Committee meeting and the timing of the audits within the plan will be considered to ensure they are as evenly spread across the year as possible.	Being received 19.05.2026
AUDIT & ASSURANCE	Internal Audit Progress Report	A&A 26/02/2.1	Develop and bring back to a future meeting, thematic analysis (cross-Wales learning/themes) using the newly developed Audit & Assurance database shared with NHS Wales organisations.	Catherine Phillips	Ian Virgil	03/02/2026	19/05/2026	ON FORWARD PLAN	An initial analysis will be received at the 3rd September 2026 meeting.	On Forward Plan for 01.09.2026
AUDIT & ASSURANCE	Internal Audit Progress Report - ALN	A&A 26/02/2.1	Liaise with Executive leads and bring the Additional Learning Needs (ALN) work forward for wider visibility and scrutiny, rather than revisiting the audit itself.	Matt Phillips, Emma Cooke	Matt Phillips, Emma Cooke	03/02/2026	19/05/2026	ON FORWARD PLAN	On Forward Plan for the Quality Committee on 2nd June 2026	Matt Phillips stated he would take this action, working with Emma Cooke and others, implied to be progressed in the next few weeks and brought to the Quality Committee
AUDIT & ASSURANCE	Internal Audit Progress Report - Quality & Safety Governance advisory review	A&A 26/02/2.1	Bring a consolidated action plan back to a future Audit & Assurance Committee, pulling together: Opportunities from the Internal Audit Quality & Safety Governance advisory review. Related actions from Audit Wales structured assessment and escalation framework work	Jason Roberts, Emma Cooke, David Fluck	Jason Roberts	03/02/2026	19/05/2026	ON FORWARD PLAN	An improvement plan went to Quality Committee which can be taken back to the Audit Committee in September 2026.	On Forward Plan for 01.09.2026
AUDIT & ASSURANCE	Risk Management Policy	A&A 26/02/3.1	Continue the programme of moving all organisational risks into the AMAT system, replacing multiple local risk registers and embedding AMAT as the single source of truth.	Matt Phillips	Andrew Partridge, Matt Phillips	03/02/2026	19/05/2026	ON FORWARD PLAN	On Forward Plan for 19th May Audit & Assurance Committee meeting.	Verbal update going to May 19th meeting on digital risk transition and Matt Phillips will talk to the position of risks in AMAT as the Committee had a comprehensive paper update in February.

Report Title:	Internal Audit Progress Report			Agenda Item no.	2.1
Meeting:	Audit & Assurance	Public	X	Meeting Date:	19/05/26
		Private			
Status:	Assurance X	Approval		Information	
Lead Executive:	Director of Corporate Governance				
Report Author:	Head of Internal Audit				

Main Report

Background and current situation:

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

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

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

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

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

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

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

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

- Occupational Health Services (Substantial Assurance)
- Risk Management & Board Assurance Framework (Reasonable Assurance)
- Neurodevelopmental Services – Children (Reasonable Assurance)
- Rhydlafar Development (Reasonable Assurance)
- Wellbeing Hub at Park View (Reasonable Assurance)
- Nurse Staffing Levels (Reasonable Assurance)
- Clinical Board Adherence to the Managing Attendance at Work Policy (Limited Assurance)
- Staff Overpayments (Limited Assurance)
- Neurodevelopmental Services – Adults (Limited Assurance)
- Digital Literacy (Advisory)
- Medical Staff Deployment (Advisory)
- Alcohol Standards Follow-up (Assurance Not Applicable)
- Decarbonisation Follow-up (Assurance Not Applicable)

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

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/

1. **Click the objective above to view more detail.**

2. **Click the objective above to view more detail.**

3. **Click the objective above to view more detail.**

4. **Click the objective above to view more detail.**

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes		No	x	Not Required

Impact Assessment:

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

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

Safety: Yes/~~No~~

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

Financial: Yes/~~No~~

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

Workforce: Yes/~~No~~

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

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

The progress report includes the outcome from audits 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~~

<table>
<tr><td colspan="2">The progress report includes the outcome from an audit that provides assurance around decarbonisation issues.</td></tr>
<tr><td colspan="2">Welsh Language: ~~Yes~~/No</td></tr>
<tr><td colspan="2">Approval/Scrutiny Route (please note anywhere else this paper has been before):</td></tr>
<tr><td>Committee/Group/Exec</td><td>Date:</td></tr>
<tr><td></td><td></td></tr>
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Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee May 2026

NWSSP Audit and Assurance Services

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Appendix A Assignment Status Schedule

Appendix B Report Response Times

Appendix C Key Performance Indicators

Appendix D Assurance on Action Tracking

Appendix E Assurance Ratings

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 May Audit Committee but did not meet that deadline.

Audit	Current Position	Draft Rating	Reason
Local / Shadow IT Systems	Draft Report	Reasonable	Delay in agreeing report and receiving management actions.
5 Steps to Safer Surgery	Draft Report	Reasonable	Delay in agreeing report and receiving management actions.
Reducing Health Inequalities	Fieldwork		Initial delay in agreeing scope and then delay in completion of fieldwork due to availability of IA resources.
Follow-ups not booked	Fieldwork		Delay in completion of fieldwork due to availability of IA resources.
Medicines Management	Fieldwork		Delays in meeting key management contacts to progress fieldwork.

3. Outcomes from Completed Audit Reviews

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

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

<table>
<tr><th>FINALISED AUDIT REPORTS</th><th colspan="2">ASSURANCE RATING</th></tr>
<tr><td>Occupational Health Services</td><td>Substantial</td><td></td></tr>
<tr><td>Risk Management & Board Assurance Framework</td><td rowspan="5">Reasonable</td><td rowspan="5"></td></tr>
<tr><td>Neurodevelopmental Services – Children</td></tr>
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<tr><td>Staff Overpayments</td></tr>
<tr><td>Neurodevelopmental Services – Adults</td></tr>
<tr><td>Digital Literacy</td><td rowspan="4">Advisory / N/A</td><td rowspan="4"></td></tr>
<tr><td>Medical Staff Deployment</td></tr>
<tr><td>Alcohol Standards Follow-up</td></tr>
<tr><td>Decarbonisation Follow-up</td></tr>
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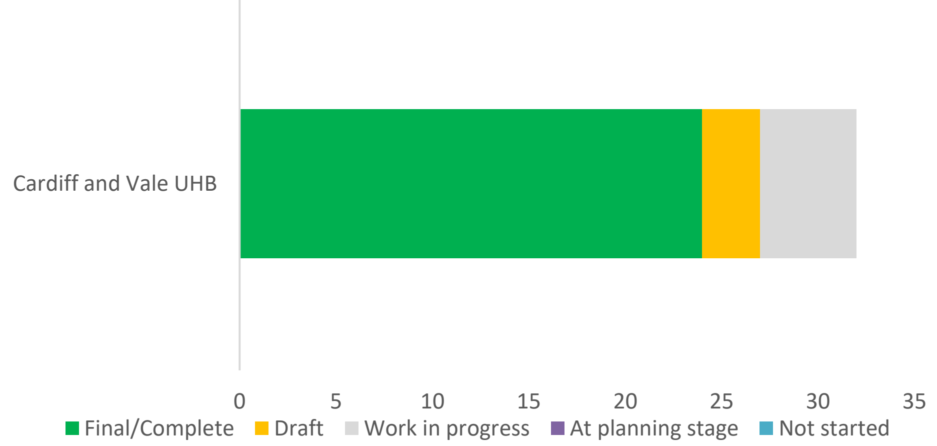
4. Delivery of the 2025/26 Internal Audit Plan

There is a total of 33 reviews within the 2025/26 Internal Audit Plan, (including the changes highlighted below), and overall progress is summarised below.



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

The remaining five audits are all currently work in progress.

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 following audits have been proposed for deferral from the 25/26 plan:

- Performance Management - Due to planned changes in the CB performance reporting ahead of the organisational re-design.
- Interventions Not Normally Undertaken Follow-up – Due to changes in the lead manager and lead Executive.
- AI Use of Robotics and Automation – Due to overlap with the scope of the Audit Wales Deep Dive into Digital.
- Planned Care Programme - Due to an overlap with the scope of the recent Audit Wales review.

An additional audit has also been added to the plan for Neurodevelopment Services Children. It was initially planned to produce one audit report covering the services for both adults and children, but due to the different outcomes we determined it would be more appropriate to produce separate audit reports.

6. Assurance on Action Tracking

The Health Board's Internal Audit Tracker within AMAT provides the Audit Committee with information on the current progress that has been made towards the implementation of outstanding actions from Internal Audit reports. The information within the Tracker is based on responses provided by Health Board management confirming the current progress.

Each year we undertake a process of reviewing a sample of the entries within the tracker, in order to validate the stated position and provide additional assurance to the Audit Committee.

Appendix B provides detail of the entries from the Tracker for which we attempted to validate implementation.

Our audit sample focused on the recommendations reported to the Audit Committee through 2025/26 as complete. As part of our assurance process, we are required to review a minimum of 50% of closed high priority actions and 10% of closed medium priority actions. A total of 57 high and medium actions were reported as complete during 2025/26, which would have required us to review at least 5 high and 5 medium actions. However, we had already reviewed 15 actions, comprising 7 high and 8 medium, during our audits and follow up reviews undertaken during the year. We therefore used these as our sample to validate to the AMAT Tracker.

Sufficient evidenced was identified as part of our testing to confirm that all the sampled actions had been completed and were correctly recorded as closed within the AMAT Tracker.

As part of our review, we did however identify that the actions for the Interventions Not Normally Undertaken (INNU) audit had been incorrectly recorded as closed. This has since been rectified and the actions have now been re-opened.

The exercise has highlighted that the Audit Committee can be reasonably assured that the progress information detailed within the Tracker for 2025/26 was accurate.

7. Final Report Summaries

7.1 Occupational Health Services

Substantial Assurance

Purpose

The review of the Occupational Health Service was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board'). The purpose of the audit was to review the current structure and robustness of the service and processes in place to ensure effective delivery against KPIs and targets.

Overview

Health and safety legislation in the UK places a statutory duty on employers to keep their employees healthy and safe whilst in work, and in particular to manage those risks in the workplace that are likely to give rise to work-related ill-health.

The Health Board values the health and welfare of its employees. The aim of the Occupational Health Service is to support the Health Board's quest to maintain and improve the health and wellbeing in the workplace for all its employees. It provides specialist advice and support on all aspects of workplace health.

The Occupational Health Service is a confidential service which is available to all staff and provides specialist Occupational Health advice to management. The service within the Health Board is delivered in collaboration with Cwm Taf Morgannwg Health Board.

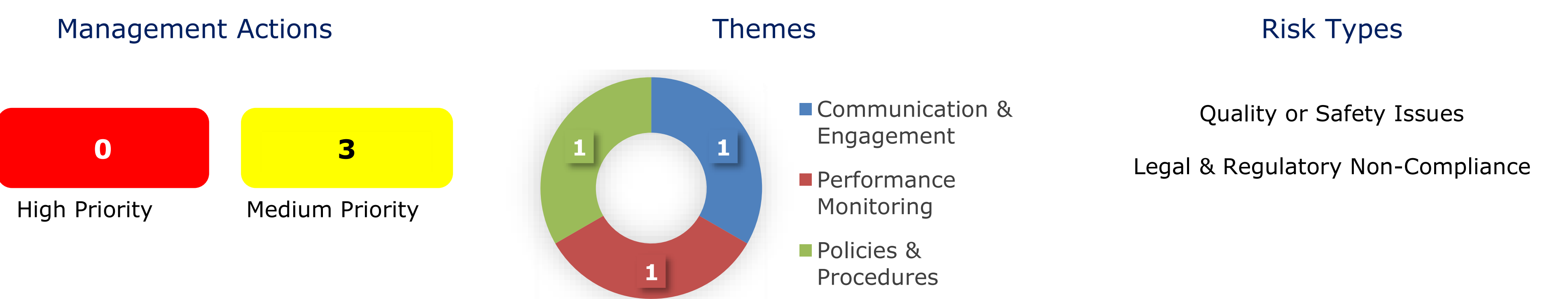
We have concluded **Substantial** assurance on this area. The current service structure and collaboration with Cwm Taf Morganwg Health Board ensures that staff have timely access to the Occupational Health Service and effective assessments are undertaken. Pre-employment checks are also being appropriately managed. The significant matters requiring management attention include:

- The Health Board does not have a standalone formal approved Occupational Health Policy.
- There were inconsistencies identified between the Occupational Health information published on the Health Board's Occupational Health SharePoint page and that available on the People and Culture pages.
- There are no formal arrangements in place for the reporting of Occupational Health KPI's to an appropriate forum.

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

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	The Health Board has a formally documented policy and standard operating procedures in place for the Occupational Health Service, and these are appropriately applied in practice	1, 2	**Reasonable**
2	Appropriate resources and processes are in place to ensure staff have timely access to the Occupational Health Service for referrals (both self and line manager)	-	**Substantial**
3	Referrals are appropriately recorded, assessments are undertaken within required timescales, and managers are informed of the next steps required	-	**Substantial**
4	Appropriate processes are in place for the completion of pre-employment checks for all prospective employees within agreed timescales following receipt from TRAC	-	**Substantial**
5	Appropriate KPI's are in place for the Occupational Health Service which are effectively monitored and reported	3	**Reasonable**



7.2 Risk Management & Board Assurance Framework

Reasonable Assurance

Purpose

To review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance Framework, with a particular focus on the Clinical Boards' use of the Audit Management and Tracking software (AMaT) system.

Overview

Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives. Risk management consists of defined steps which help to understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice.

The Board Assurance Framework (BAF) provides the Board with the key strategic risks that could impact upon the delivery of the Health Board's Strategy. The Corporate Risk Register (CRR) ensures the Board has an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The BAF continues to be reported to every Board meeting with updates shown using track changes. There is a clear and explicit link to the strategic objectives of the Health Board and Independent Members interviewed as part of our audit were appreciative of the work undertaken to develop the BAF. Specific strategic objectives within the BAF are allocated to Board sub-committees and whilst there is a marked improvement from the prior year in the way that sub-committees meet this responsibility, there remains an inconsistency of approach.

The migration of risks onto AMaT appears to have gone well with oversight and direction provided by a Task and Finish Group. Comprehensive and informative guidance has been provided by the Corporate Governance Team in both written and video format, and staff interviewed from four different areas of the Health Board were extremely positive on both the support that they had received in transferring to AMaT, and the functionality of AMaT to improve their management of risks. It is estimated that 1500 risks will have been populated onto the system by the end of March 2026, and whilst some data cleansing and housekeeping has taken place to date, there is a further target of September 2026 to ensure that all risks on AMaT are fully reviewed. The implementation of AMaT will hopefully support a significant refresh of the Corporate Risk Register. As was the case last year, the CRR is reported to each Board meeting but contains far too many risks (186 reported to the March 2026 Board) to enable Board members to review this in any meaningful way.

Until now, the role of the Audit Committee in reviewing risk has been relatively limited, and this marked the Health Board as an outlier in this respect compared to all other NHS organisations in Wales. However, we have been advised that with effect from the May 2026 meeting, the Audit Committee will receive a twice-yearly update on risk management.

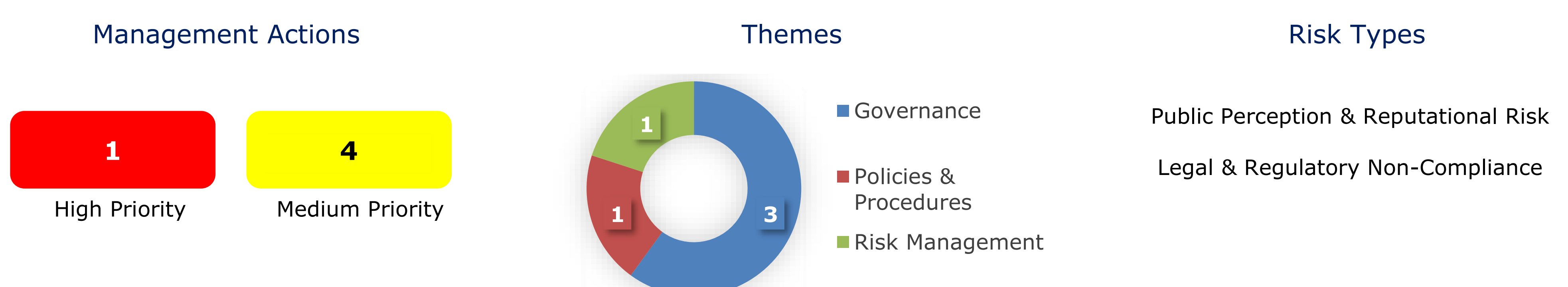
We have concluded **reasonable** assurance on this area. The matters requiring management attention are:

- The Risk Management Policy has recently been updated but contains some inconsistencies, and links to supporting documentation which is out of date.
- Risks transferred onto AMaT need to be reviewed to ensure they remain current and relevant.
- Whilst there has been demonstrable progress in the role of the Board sub-committees managing their allocated risks on the BAF, the approach is still inconsistent and often lacks an explicit link to the BAF.
- The Clinical Board Performance Reviews undertaken by the Executive Team do provide an opportunity to drill down into Clinical Board risks, but as with the Board sub-committees, the approach appears inconsistent and without an explicit link to key risks.
- Although the Corporate Risk Register is reported to each Board meeting, it contains too many risks to be manageable by the Board and is consequently never reviewed in any detail.

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

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Risk Management and Assurance arrangements are defined within an up-to-date Strategy and Framework and associated procedures, aligned to the Health Board's objectives and strategic direction.	1	**Reasonable**
2	Clinical Boards have reviewed all their risks and ensured that only relevant risks are recorded on their risk registers within the AMaT system.	2	**Reasonable**
3	There are clear and consistent processes in place for the identification, classification, scoring and recording of risks throughout clinical boards down to directorate and departmental level.	1	**Reasonable**
4	Comprehensive risk registers are in place for clinical boards, through to directorates and departments with appropriate risk owners identified and effective escalation/de-escalation of risks.	2	**Reasonable**
5	Risks are actively monitored and scrutinised at an appropriate level within the clinical boards, directorates and departments.	3	**Reasonable**
6	Key operational risks from the Clinical Boards and Corporate Directorates Risk Registers are escalated to the CRR and principal risks to the achievement of the Health Board's strategic objectives are recorded in the BAF.	4	**Reasonable**
7	Strategic and corporate risks are regularly reviewed, and processes are in place to support, and evidence changes in risk scores.	5	**Reasonable**
8	The audit will identify the progress of implementing the internal audit recommendations raised in the 2024/25 audit of Risk Management. (CVU-2425-01).	1,4,5	**Reasonable**



7.3 Neurodevelopmental Services – Children

Reasonable Assurance

Purpose

The purpose of our audit was to review the procedures for assessing whether children are added to waiting lists, and the subsequent management of those lists to ensure that those referred are assessed in a timely, fair and consistent manner.

Overview

The original scope of our review covered referrals for both Adults and Children for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD). Due to the significant differences in approach between services for children and adults, we agreed with the Health Board to produce separate reports and so this report relates solely to the services provided for children.

The demand for Neurodevelopmental services, covering both ADHD and ASD, have increased exponentially over recent years (between February 2022 and December 2023 the Health Board experienced an 136% increase in children waiting for an assessment). At the time of our review at the end of 2025 there were 4,700 children on the waiting list, with an expected wait time of 3.5 years for an assessment. Although additional funding is often received from Welsh Government to reduce waiting lists (currently there is funding to reduce the wait to under three years which requires approximately 1,000 children to be seen by the end of the financial year), this is on a non-recurring basis and is often received too late in the year to enable recruitment. Private contractors, weekend waiting list initiatives and outsourcing activity to other Health Boards are currently being utilised to carry out assessments to meet the Welsh Government targets, but whilst this may reduce the waiting list for a diagnosis, it also just shifts the wait along a step to the provision of care plans and medicines.

ADHD diagnosed children are required to be followed up every three months until they reach primary school age and then every six months thereafter until adulthood. So, as more children are diagnosed with ADHD, the number of available appointments for new referrals is reduced. ASD children are generally discharged once they get a diagnosis and care plan and there is a move towards making this a formal protocol for all ASD children apart from those that have severe conditions that impact their ability to function.

The Health Board has introduced several measures to address the surge in demand on services for ADHD and ASD. Children under the age of six and those assessed to have more complex needs are seen by doctors. All other assessments are undertaken by psychologists, speech and language therapists and occupational therapists. Clinics have been rescheduled such that each session is a mixture of new referrals and follow-ups, rather than having a clinic session just for new referrals or follow-ups. This has been welcomed as the new referrals can be quite exhausting and time-consuming and therefore a mix of patients reduces some of the pressure on the service. Most referrals are received via schools and there are standard questionnaires to ensure that all required information is received at the first attempt. Work is also being undertaken on a standard process for the growing number of children that are home-schooled. The Informed Care Pathway aims to make the assessment process leaner and smarter. Referrals to Speech and Language Therapy or Occupational Therapy for children are viewed through a neurodevelopmental lens so that if, as is often the case, there is a subsequent referral for a potential ADHD or ASD diagnosis, relevant information on the child has already been obtained to inform the clinical pathway. Assessment appointments are now being recorded on film, with parental consent, rather than taking manual notes. This not only saves time but ensures that those undertaking the assessment can fully observe the child throughout the assessment rather than having to also take notes.

In the context of the specific objectives of our review, and the overwhelming demand for Neurodevelopmental services, we have concluded **reasonable** assurance on this area. We consider that the Health Board is generally doing all that it can to make the process as effective as possible with the resources that are available to it. The Health Board is unable to address the demand for services on its own – it needs the Local Authority and education providers to also play a role on delivering a whole systems approach.

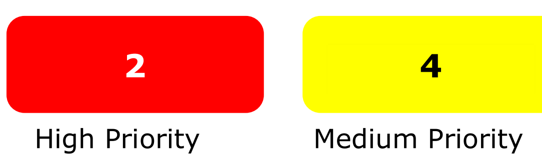
The significant matters requiring management attention are:

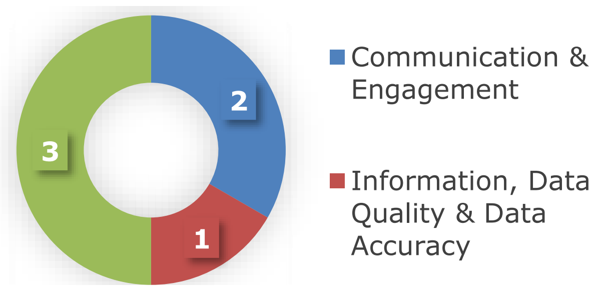
- The team undertaking the triage assessments have not been recruited to the intended full capacity with resulting detrimental impact on resilience and development activities with schools which could help to reduce the number of referrals.
- There is insufficient recurring capacity to undertake assessments and meeting Welsh Government targets can only be achieved currently through a combination of outsourcing and weekend working which is not sustainable over the longer term.
- Significant time savings could be made by a suggested automation of triage outcomes, but the Health Board would need to ensure that these do not become too generic and impersonal.
- Insufficient administrative support results in there being no proactive management of waiting lists, and clinical and nursing staff having to undertake administration tasks thereby reducing the time available to be spent on direct patient care.
- The provision of timely and accurate management information is adversely impacted by the limitations of the current reporting systems, which are approaching end of life.

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

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Referrals to the service for children are subject to a formal and consistent form of triage.	1	**Reasonable**
2	All children referred are notified on a timely basis as to whether they have been accepted for inclusion on waiting lists for neurodevelopmental services.	2	**Reasonable**
3	All accepted patients are added to the waiting lists promptly, and lists are appropriately managed and accurately updated in terms of any changes notified to the Health Board.	3,4,5	**Limited**
4	Any patients removed from waiting lists due to failure to attend appointments are notified that they have been discharged from the service.	4	**Reasonable**
5	The process for transition from Children's to Adult Services is formally documented and complied with.	-	**Not Applicable**
6	Management Information reported to assess the performance of the service is accurate and up to date.	6	**Limited**





Quality or Safety Issues

Public Perception & Reputational Risk

7.4 Rhydlafar Development

Reasonable Assurance

Purpose

This audit reviewed the delivery and management arrangements in place to progress the Pentyrch/Rhydlafar Branch Surgery Development. The audit was commissioned in accordance with the agreed Integrated Audit Plan provided within the approved Business Justification Case (BJC) for the project and is the first audit of the project.

Overview

Pentyrch Branch Surgery has been operating from a temporary portacabin for the last 11 years, with the current site not fit for purpose, insufficient for increasing demand, and unsustainable noting that temporary planning permissions cannot be renewed. The relocation of the Branch Surgery to a new, purpose-built development at Rhydlafar Drive aims to expand and improve the range of services offered and accommodate increasing patient numbers in line with local development plans.

Progression of the project was initially delayed due to an external review of the engagement processes applied, with the appointed third-party developer subsequently withdrawing from the scheme in 2023 due to increased costs. The project is now being delivered via Welsh Government capital funding, with the Health Board subsequently purchasing the intellectual property rights for the work completed with the third-party developer.

We have concluded **reasonable assurance** at this review. The project was forecast to be completed within budget at the time of review, however, was three months behind schedule with the potential for further delays highlighted. Management controls have been assessed positively in all objective areas, with only a small number of matters requiring management attention, as follows:

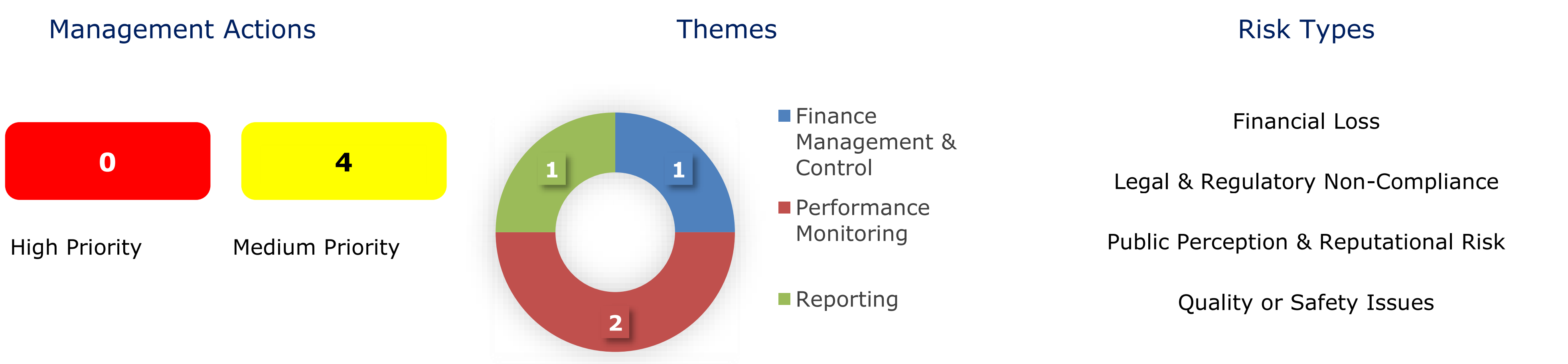
- Key Performance Indicators had not been completed in line with Local Framework requirements.
- Planning conditions were not being centrally monitored or reported.
- A Project Bank Account was not implemented in accordance with Welsh Government policy.
- Errors have been noted in the reporting of project progress to Welsh Government.

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:

- Management should consider the recording and reporting of community benefits, including to Welsh Government via their reporting tool.
- The updated Communications & Engagement Sub-Group terms of reference should be reported back to the Project Team for approval.
- A potential error at the Bill of Quantities should be checked and corrected if necessary.

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	**Project Performance**: Consideration of performance against project objectives at the current stage (e.g. time, cost, benefits, critical success factors etc.).	1	**Reasonable**
2	**Governance arrangements**: Assurance that adequate governance arrangements are in place.	-	**Reasonable**
3	**Design Development**: A review of the arrangements to develop the design, including engagement with key stakeholders. That affordability is appropriately monitored and controlled.	2	**Reasonable**
4	**Contractual**: To ensure that appropriate mechanisms have been applied at the appointment of the contractor and advisers, ensuring compliance with local and national protocols.	-	**Substantial**
5	**Financial**: Adequate cost control and reporting systems are operated. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds.	3,4	**Reasonable**
6	**Technical**: Adequate processes and procedures are in place to validate the costs incurred in accordance with the requirements of the contract.	-	**Substantial**



7.5 Wellbeing Hub at Park View

Reasonable Assurance

Purpose

This audit reviewed the delivery and management arrangements in place to progress the Wellbeing Hub @ Park View project during the Full Business Case (FBC) stage. The audit was commissioned in accordance with the agreed Integrated Audit Plan provided within the approved Outline Business Case (OBC) and was the first audit of the project. Further audits are planned within the updated Integrated Audit Plan provided to management for inclusion within the FBC.

Overview

We have concluded **reasonable assurance** at this audit.

The project has significantly increased in cost between the OBC and FBC stage and was nearly two years behind the delivery timeline established within the OBC at the time of audit fieldwork. The FBC revenue case initially failed to achieve internal approval, leading to a further 3-month delay, and delays had also been experienced in obtaining planning approvals, putting the project timeline further at risk. The report recognises however that the cost increases were largely due to external factors outside the control of the Health Board, and we have determined positive assurance ratings in each objective related to management controls.

The significant matters requiring management attention include:

- Noting insufficiencies in delivery of the 'project board' role to date, and recent changes in the governance structure, clarification is required as to how this key role will be fulfilled going forward;
- A review of contractual arrangements to ensure contract documents are appropriately executed in line with Standing Orders, and forms of contract applied for adviser appointments appropriately reflect the complexity and size of the instruction;
- Ensuring at future projects, the target cost report is received in a timely manner to facilitate internal scrutiny and approvals;
- Improved processes to ensure a clear audit trail of timely escalation of significant project cost increases, both internally and to WG;
- A review of the approach taken in obtaining support for and approval of the FBC revenue case, to learn how this can be improved at future projects to avoid last minute rejections which may have significant impact on the project's ability to progress.

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

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	**Project Performance**: Consideration of performance against project objectives at the current stage (e.g. time, cost, benefits, critical success factors etc.).	-	**Limited**

2	**Governance arrangements**: Assurance that adequate governance arrangements exist including ownership, defined roles & responsibilities and clearly defined accountability & delegation arrangements.	1-4	**Reasonable**
3	**Approvals**: Assurance that appropriate internal / external approval mechanisms are applied as the project progresses through key junctures.	11	**Reasonable**
4	**Financial**: Adequate cost control and reporting systems are operated.	1	**Reasonable**
5	**Contractual**: To ensure that appropriate mechanisms have been applied at the appointment of contractors and advisers / design team members, ensuring compliance with local and national protocols.	5-7	**Reasonable**
6	**Planning:** Assurance that planning approvals have been appropriately obtained, and conditions/requirements are complied with.	-	**Reasonable**
7	**Design Development**: A review of the arrangements to define and sign-off the client brief and the engagement processes thereafter with key stakeholders to develop the design.	8-10	**Reasonable**

7.6 Nurse Staffing Levels

Reasonable Assurance

Purpose

Our audit of Nurse Staffing Levels was completed in line with the 2025/26 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board'). The purpose of the audit was to review the processes in place to ensure compliance with the requirements of the Nurse Staffing Levels (Wales) Act.

Overview

The Nurse Staffing Levels (Wales) Act became law in March 2016. The Act requires health service bodies to make provision for appropriate nurse staffing levels and ensure that they are providing sufficient nurses to allow the nurses' time to care for patients sensitively.

The nurse staffing level is the number of Nurses (registered Nurses and others to whom the registered Nurses delegate care tasks) appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. Nurse Staffing Levels are reviewed within Adult acute medical inpatient wards, Adult acute surgical inpatient wards and paediatric inpatient wards.

SafeCare is actively used within the Health Board to allow Ward Managers to record Nurse attendance on the ward for both day and night shifts. Attendance is confirmed in SafeCare by marking a green tick. Any changes to nurse staffing must also be promptly updated in SafeCare.

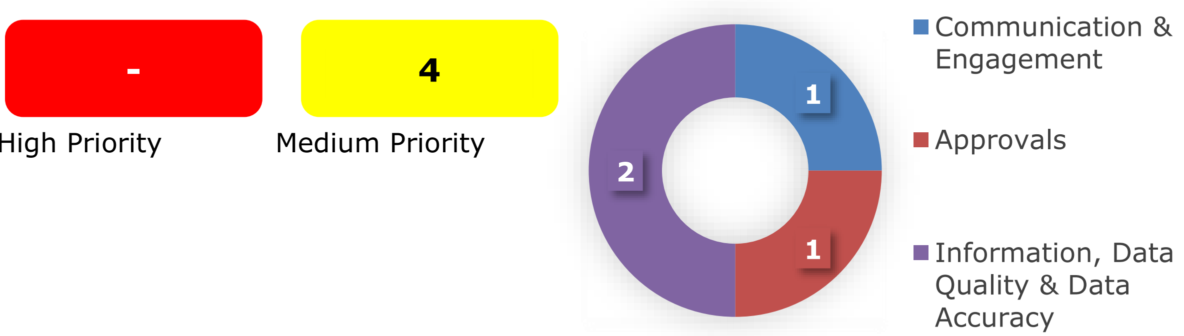
We have concluded **reasonable** assurance on this area. The matters requiring management attention are:

- Establishment sheets were not consistently fully complete or signed by all required individuals.
- SafeCare census data for staffing levels was not always updated to achieve the over 90% completion threshold stipulated within the Nursing Rostering Principles.
- Where staffing levels had been recorded as "red flags", Healthroster was not consistently updated to reflect the actions taken and outcomes achieved.
- Nurse staffing level information was not always displayed on the wards, or where displayed, was out of date and not being displayed in Welsh.

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

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Nurse staffing levels are calculated using the prescribed methodology for wards (as defined within the statutory guidance of Section 25B of the Act) and these levels are reviewed twice annually in accordance with the requirements of the Act.	1	**Reasonable**
2	Staff are undertaking the SafeCare census twice daily including recording the actual staffing levels on the ward and reviewing any variations	2	**Reasonable**
3	Appropriate actions are taken to enable wards to maintain nurse staffing at the calculated levels	3	**Reasonable**
4	Effective processes are in place to ensure that patients are informed of the nurse staffing levels in accordance with the requirement of the Act.	4	**Reasonable**
5	Nurse staffing levels are reported to the Board and Welsh Government in accordance with Section 25E of the Act detailing the extent to which levels have been maintained, the impact of any shortfall and action taken	-	**Substantial**



Public Perception & Reputational Risk

Quality or Safety Issues

7.7 Clinical Board Adherence to the Managing Attendance at Work Policy

Limited Assurance

Purpose

The overall purpose of this audit was to review how requirements of the All Wales Managing Attendance at Work Policy are implemented within Clinical Boards to ensure that sickness absence is being effectively managed.

Sickness absence represents a significant cost to the Health Board both directly and indirectly and has an adverse effect upon employees and on the level and quality of service that the organisation provides. Effective monitoring of all forms of absence, and a consistency of approach, are essential if absence levels are to lower and be maintained at, or below, the target levels set by Welsh Government. The All Wales Managing Attendance at Work Policy provides the framework for the consistent management of absence across all staffing groups in all NHS Wales organisations.

The Welsh Government has set all NHS organisations a performance measure to reduce their sickness absence percentage rates over a 12-month period. The Health Board has set itself a target of below 5.5% for 2025-26, with measures being put in place to support the achievement of this goal. Sickness Absence is reported under 'Quadruple Aim 3: People and Culture' within the Integrated Performance Report. In the January 2026 report it was stated that 'the monthly sickness rate for December 2025 was 6.43%. The 12-month cumulative rate has risen slightly during the past year.'

A MDT approach has been adopted, bringing together People Services, Wellbeing, OD & Culture, Employee Wellbeing and Occupational Health to drive improvements in wellbeing and attendance. A high-level action plan has been developed, and a task and finish group has been established to oversee its implementation. In addition, each Clinical/ Service Board has developed an individual, detailed and targeted action plan to reduce sickness absence in their respective areas. Updates are provided to the People and Culture Committee to show progress against the overall sickness absence target.

Overview

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

- Guidance for managers on how to record an absence in the system has not been consolidated with the digitalised Managing Attendance training, leading to uncertainty for managers in how these records should be processed and errors in sickness recording.
- Supporting documentation for justification of an absence (self-certifications / Fit notes) are not routinely provided and system fields designed to capture this information have not been made mandatory.
- Review prompts are actioned irregularly with a significant number outstanding for all trigger points defined by the policy.
- A significant number of return-to-work meetings had not been completed and of those that had, the majority were not held within a reasonable period from return.

Full details of matters arising are included 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:

- A training needs analysis should be formalised to provide detail on the level of training required by differing levels of management in respect of Managing Attendance. This analysis should include guidance on when training should be refreshed.

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	Appropriate policies and procedures for managing sickness absence are in place, with training and guidance available for those managers who have a responsibility for managing sickness absence.	1	**Reasonable**
2	Sickness absence is appropriately recorded in ESR or other systems that feed into ESR.	1, 2	**Limited**
3	Sickness absence is appropriately managed in line with the All Wales Managing Attendance at Work policy, with mechanisms in place to promote and support staff wellbeing and minimise absence.	3, 4	**Limited**
4	Monitoring and reporting of sickness absence is undertaken at appropriate levels within the Health Board	-	**Substantial**

Management Actions

High Priority

Themes

Risk Types

Financial Loss

7.8 Staff Overpayments

Limited Assurance

Purpose

Our review of Staff Overpayments was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board.

There is an All Wales 'Procedure for the Recovery of Overpayments' (the 'Procedure') which aims to standardise the recovery of overpayments to ensure consistency across NHS Wales. The Procedure confirms the most common reasons for overpayments which are:

- Late Termination Notification;
- Late and inaccurate update of employee or worker contractual hours;
- Late and inaccurate update of an employee or worker absence (sickness, Maternity, unpaid leave etc);
- Late or inaccurate reporting of enhancements, overtime, on call, start date, salary, banding etc; and
- System errors.

NHS Wales Shared Services Partnership (NWSSP) Payroll have created a 'live' dashboard where Managers can view the overpayments in their area as soon as it's discovered by NWSSP Payroll. Information from the dashboard is reported to the Health Board's Private Audit and Assurance Committee.

A Staff Overpayments Task and Finish Group was established for six months during 2024/25 with the purpose of decreasing/ eradicating the number of overpayments across the Health Board. It was agreed that we would undertake our sample testing within the Medicine, Children & Women and Specialist Services Clinical Boards to understand compliance with processes.

Overview

The Private Audit and Assurance Committee were provided with a report confirming that the staff overpayments for the period April to December 2025 totalled £899k. We have concluded **Limited assurance** on this area. The significant matters requiring management attention include:

- Limited awareness and inconsistent communication of the All-Wales Recovery of Overpayments Procedure, evidenced by over half of surveyed supervisors being unaware of the policy and some being unsure how to access it, increasing the risk of continued payroll errors.
- Workforce Induction Toolkits for new managers omitted both the All-Wales Procedure for the Recovery of Overpayments and the SMA app. The Leavers Checklist lacks reference to overpayments but does link to the SMA app; however, supervisors showed limited awareness or use of the checklist.
- Users have inconsistent understanding of when to use MSS, SMA, and Health Roster, leading to confusion and risks to staff data accuracy. There are also notable gaps in awareness of key SMA app features, such as editing submissions, tracking issues, and delegating tasks.
- Testing for non-medical staff overpayments highlighted late notifications, unclear roles, poor training, and inconsistent use of Staff in Post and related systems.
- Recurring administrative delays and missed notifications continue to cause medical staff overpayments, including late terminations, unrecorded unpaid leave, and missed payroll adjustments.
- Inconsistent distribution, and unclear use of overpayments dashboards delay effective oversight and timely action across Clinical Boards.

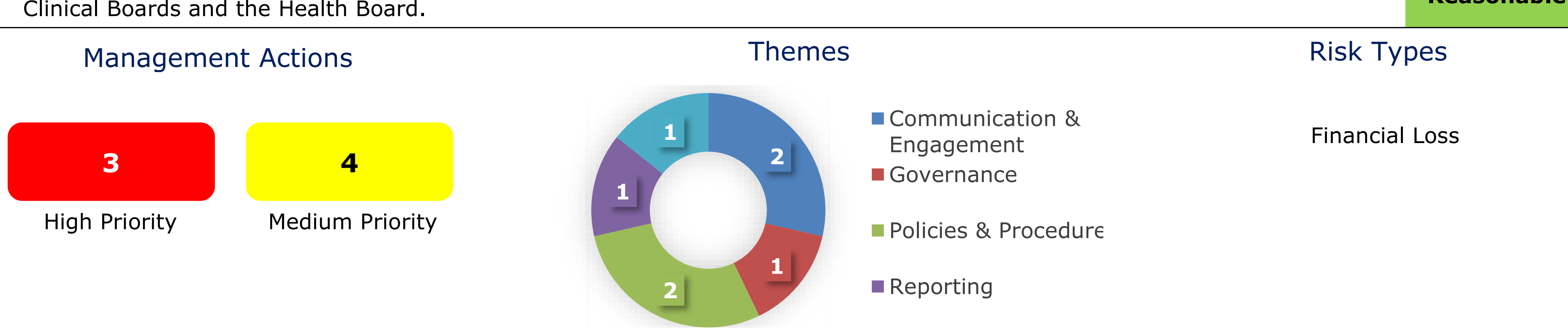
- Clinical Board-level oversight of staff overpayments is inconsistent and lacks sufficient integration, with responsibilities for monitoring and escalation remaining unclear.

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:

- The 26/27 Payroll Submission timetable needs to be disseminated to all relevant staff, and the SharePoint link needs to be updated.

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	Staff are aware and are complying with the All-Wales Procedure for the Recovery of Overpayments	1	**Reasonable**
2	Line Managers have been provided with adequate information and training on the procedures for processing staff changes, terminations and absences and are aware of and comply with the timescales for actioning them	2,3	**Limited**
3	Clinical Boards and Medical Workforce action changes, terminations and absences in a timely manner for medical staff.	4,5	**Limited**
4	Effective monitoring, reporting and scrutiny of staff overpayments takes place at appropriate levels within Clinical Boards and the Health Board.	6,7	**Reasonable**



7.9 Neurodevelopmental Services – Adults

Limited Assurance

Purpose

The purpose of our audit was to review the procedures for assessing whether adults are added to waiting lists, and the subsequent management of those lists to ensure that those referred are assessed in a timely, fair and consistent manner.

Overview

The original scope of our review covered referrals for both Adults and Children for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactive Disorder (ADHD). Due to the significant differences in approach between services for children and adults, we agreed with the Health Board to produce separate reports and so this report relates solely to the services provided for adults. There are also significant differences in the services provided to adults for ASD and ADHD. ASD referrals are largely directed to the Integrated Autism Service, which is a Welsh Government funded initiative established in 2017. ADHD referrals have no stand-alone service and therefore the Health Board's Community Mental Health Teams (CMHTs) have had to take on responsibility for the referrals without any significant additional resource. Any additional Welsh Government funding for ADHD services is currently being totally directed at children.

Whilst waiting lists for ASD referrals are increasing, our review did not note any significant issues with this service. The procedures for dealing with ADHD referrals do however raise significant concerns, in spite of these being subject to substantial change during the course of our review. At the start of our fieldwork, interviews with key staff demonstrated that there was an inconsistent approach to ADHD referrals across the CMHTs and that this led to a perception of a postcode lottery within the Health Board. This inconsistency has since been addressed by the issue of a Standard Operating Procedure (SOP), which although in draft at the time of our review, was already being adopted across the CMHTs. Although all referrals are initially screened by a multi-disciplinary team, the instruction via the SOP is that they will now be automatically added to the waiting list unless their needs are more complex in which case they will be seen more urgently. The rationale for this approach is that if referrals are not accepted to the waiting list, patients often submit complaints, which in turn takes up considerable clinical time to address. The SOP also states that one in ten appointments should be given over to an ADHD referral (but this can be less dependent on demand for other services) and given that once a patient is diagnosed with ADHD they need to be followed up on a regular basis, the availability of appointment for new referrals comes under increasing pressure. Shared Care responsibility is only accepted from a small proportion of GP surgeries resulting in stabilised patients being kept indefinitely on CMHT caseloads for perpetual monitoring and prescribing of medication. Clinicians interviewed during our audit were of the opinion that those joining the waiting list now are unlikely to ever be seen unless there is a radical change in approach. Their preference would be for a specialist nurse-led service that could be overseen by clinicians. Currently, the most skilled, highly trained and expensive resource (consultant psychiatrists) are seeing the population of CMHTs with the lowest need in comparison to the rest of their workload. Moving to a nurse-led service, for which a detailed business case has previously been produced but not progressed, would be a more effective use of resource but would require substantial investment to establish it.

The root cause of the issues with ADHD referrals is obviously the surge in demand for services and this issue is replicated across the UK with a number of NHS Trusts in England seeking to close their waiting lists to new adult ADHD referrals. Limitations with current reporting systems make it difficult to accurately predict numbers and wait times but a report by ThirtySixDegrees, who are a specialist consultancy undertaking a review of Adult Mental Health Services for the Health Board, quoted that as of December 2025, 3,762 people were waiting for an ADHD assessment across the Health Board's CMHTs with suggested wait times of between 20 and 50 months dependent on the CMHT, as each operates their own waiting list. Feedback from those interviewed during our review suggested wait times of eight years and possibly longer for those now joining the lists. Work was ongoing during our audit to identify children approaching the age of 18 who had not yet been seen by children's services and who therefore should normally transition to the adult waiting list. It is estimated that this would increase the wait time for those currently at the end of the adult waiting list by a further year, and that this increase will be replicated annually going forward. We now understand that Adult Services are refusing to take on these cases (for ADHD and ASD) and they will remain on the children's list. The figures reported for Adult Mental Health performance in the Integrated Performance Report do not cover neurodevelopment services for adults although the performance for children is reported.

We have concluded **limited** assurance on this area. The significant matters requiring management attention (acknowledging the financial constraints on the Health Board) are:

- The service is being delivered by a highly skilled, trained, and expensive resource when it could largely be a nurse-led service, with consultant psychiatrist oversight. The current approach to managing ADHD referrals is unsustainable and results in extremely long waits for patients, with patients joining the waiting list now possibly never likely to be seen.
- Referrals are not received in a consistent format which can result in inefficiencies in the process as more information may be required.
- Unlike children's services and ASD, there is no stand-alone service for adult ADHD referrals and consequently there is very limited information for adults and their families who may be exploring a potential ADHD diagnosis.
- A majority of GPs are refusing to take back stabilised patients resulting in the Health Board effectively having to follow them up for life.
- There is insufficient administrative support resulting in tasks either not being completed or being undertaken by clinicians and/or nurses, reducing capacity for direct patient care.
- Management information is very limited and the system for recording and reporting patient data is nearing end-of-life.

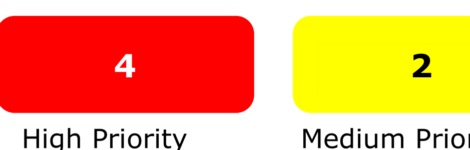
Full details of matters arising are provided within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Although non-attendance of patients for scheduled appointments is not seen as a particular problem due to patients being contacted for updated information shortly before their appointment, there is not a consistent approach between ASD and ADHD services, and in the case of the latter between the CMHTs to minimise the number of DNAs.

Scope & Assurance Summary

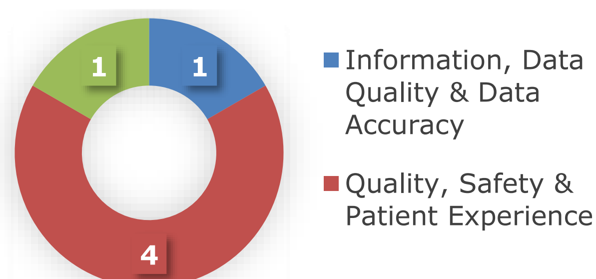
Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Referrals to the service for adults are subject to a formal and consistent form of triage.	1,2,3,4	**Unsatisfactory**
2	All adults referred are notified on a timely basis as to whether they have been accepted for inclusion on waiting lists for neurodevelopmental services.	-	**Substantial**
3	All accepted patients are added to the waiting lists promptly, and lists are appropriately managed and accurately updated in terms of any changes notified to the Health Board.	5	**Reasonable**
4	Any patients removed from waiting lists due to failure to attend appointments are notified that they have been discharged from the service.	-	**Substantial**
5	The process for transition from Children's to Adult Services is formally documented and complied with.	-	**Not Applicable**
6	Management Information reported to assess the performance of the service is accurate and up to date.	6	**Limited**

Management Actions



High Priority Medium Priority

Themes



Risk Types

Quality or Safety Issues

7.10 Digital Literacy

Advisory

Purpose

Review the plans to assess and improve the level of digital literacy within the Health Board to prepare the organisation for digital transformation.

Overview

The organisation currently lacks a consistent, coordinated, and role specific approach to assessing digital literacy and capability across its workforce. Although multiple strategic plans, including the People and Culture Plan 2022–2025, Digital Strategy 2020-2025, Digital Foundations Programme, and the Health Board's Annual Plan 2025/26, all identify improving digital literacy / capability as an objective, progress towards establishing a digital skills framework and conducting an organisation wide assessment has been limited. Attempts to use the HEIW Digital Capability Framework (DCF) have resulted in low engagement, preventing meaningful analysis. Without an agreed organisational assessment method or clear role-based expectations, it remains difficult to understand staff digital literacy and capability at scale or determine where training is most needed.

In the absence of central coordination, several localised assessments and training initiatives have emerged. While these efforts demonstrate initiative and highlight genuine need, they are isolated, resource-intensive, and do not contribute to a cohesive organisational picture.

Plans by the Education, Culture and Organisational Development (ECOD) Team to establish a Digital Capability Workgroup/Project represent an important step toward creating a unified assessment approach. However, it is recognised that this will be a substantial undertaking for the team and will require significant resource. For this work to be successful, it will require strengthened collaboration across Digital, People and Culture, and wider operational teams, supported by clear and consistent communication with staff.

Although a considerable amount of digital training exists, stakeholders highlighted issues with accessibility, format, communication, and time. Limited awareness of available support and training, as well as small training teams with stretched capacity may limit uptake. Staff who do not regularly access SharePoint (the intranet site) or the IT portal (Ivanti) face additional barriers as this is where the training is available and shared.

The absence of a digital literacy baseline makes it challenging to determine whether existing training is aligned with organisational needs or targeted at the right staff groups. With training resources already constrained, prioritisation is essential. Defining a clear organisational expectation for digital literacy by role, and understanding where staff currently stand, will be critical to ensuring training is purposeful, accessible, and impactful.

As this is an advisory review no assurance rating is provided. We have identified opportunities that the Health Board may wish to take forward to strengthen processes, and these are detailed within the Findings & Management Considerations section.

Scope & Assurance Summary

	Objectives	Related Opportunities
1	A process is in place to assess the digital literacy of staff against the requirements of their role and the required investment in training and development is reflected in the Health Board's digital transformation plan.	1, 2, 3, 4,
2	Training and development is in place for staff to improve their digital literacy.	5, 6, 7, 8, 9

Themes

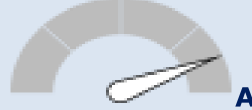
- Communication & Engagement
- Information, Data Quality & Dat Accuracy
- Lessons Learnt
- Performance Monitoring
- Planning, Delivery & Deadline Management

Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

7.11 Medical Staff Deployment


Advisory

Purpose

The advisory review of Medical Staff Deployment was completed in line with the 2025/26 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

The effective deployment and management of the medical workforce is critical to the delivery of safe, timely, and high-quality care across the Health Board. In recognition of this, the Health Board has committed to strengthening its systems and processes for medical job planning, e-rostering, annual leave and sickness absence management. These functions are essential not only for operational efficiency but also for workforce wellbeing, regulatory compliance, and financial sustainability.

The advisory review considered the Health Board's plans for alignment of job planning with demand and capacity modelling, the integration and interoperability of rostering systems, and the visibility and accuracy of annual leave and sickness absence data. We examined the plans for allocation and accountability of Supporting Professional Activities (SPA), which represent a significant proportion of consultant time and cost. We also assessed the role of leadership, communication, and workforce support in embedding sustainable change.

The job planning component of the audit specifically focussed on Consultants and SAS Doctors, while the annual leave sickness and rostering aspects extended to all medical personnel.

Overview

This advisory review assessed the robustness of Cardiff and Vale University Health Board's arrangements for deploying its medical workforce, focusing on four core areas: overarching job planning, rostering, and the management of medical annual leave and sickness. Evidence gathered through detailed fieldwork, interviews with senior medical and workforce leaders, review of Medical Workforce Advisory Group (MWAG) governance papers, and analysis of job planning and rota datasets highlighted clear strategic intent and meaningful progress in some areas, particularly job planning compliance, which improved steadily through 2025. However, several controls are not yet fully effective. Rostering remains fragmented across multiple systems, job plans are not routinely informed by demand and capacity modelling, and sickness and annual leave data are dispersed across a number of Health Board systems such as Electronic Staff Record (ESR), Codi/Intrepid and local trackers, limiting visibility and assurance. Governance structures are strong, but their effectiveness is reduced by inconsistent data quality and system integration.

As this is an advisory review no assurance rating is provided. We have made the following observations and identified opportunities that the Health Board may wish to take forward to strengthen processes, these are detailed further within Appendix A: Opportunities for improvement and development:

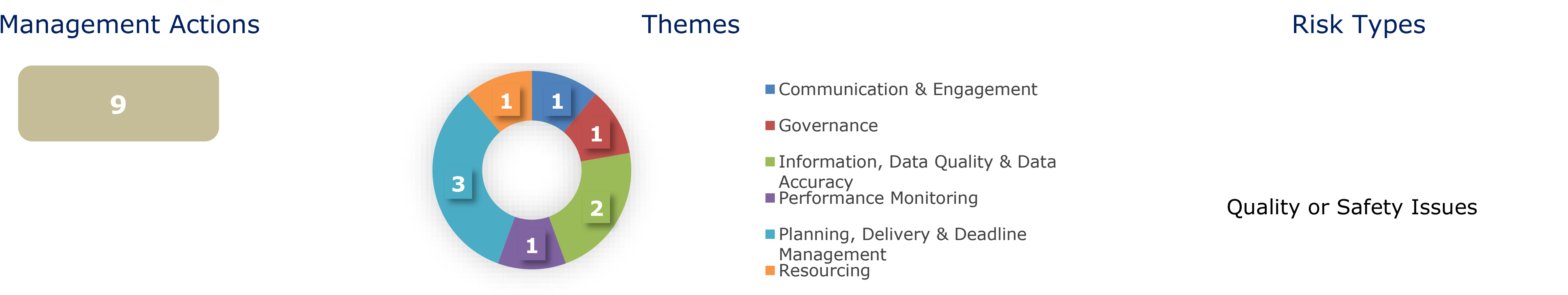
- The Medical & Dental Workforce Workplan provides a strong foundation but lacks defined risks, interdependencies and realistic delivery metrics.
- Annual leave does not feature as a standalone workstream within the 2025/26 Medical & Dental Workplan, resulting in no defined milestones, ownership or measures to address known variation and visibility gaps.
- Rostering arrangements remain fragmented across multiple systems, resulting in inconsistent practices and limited visibility of medical deployment.

- Significant variation and non-compliance across 115 rota templates creates operational burden and impacts the Health Board's readiness for implementation of the national e-roster solution.
- Sickness and annual leave processes are under-developed and fragmented across systems, leading to incomplete visibility of medical workforce availability.
- Job planning compliance is improving but remains misaligned with service need due to limited modelling and lack of integration with rostering systems.
- The terms of reference for MWAG are out of date and would benefit from a review and update.
- MWAG's ability to scrutinise sickness and annual leave is restricted by the absence of consolidated datasets and inconsistent reporting.
- Engagement and communication challenges across clinical and corporate teams reduce the effectiveness and pace of governance oversight.

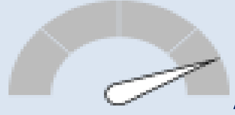
Full details of matters arising are detailed within the Findings & Agreed Actions.

Scope & Actions Summary

	Objectives	Related Actions
1	Plans are in place to take forward and improve the recording of job planning, rostering, annual leave and sickness management within the Health Board, with clearly defined actions, timescales and outcomes, and these are monitored and updated regularly.	1,2,3,4,5, 6 and 7
2	There are effective governance and monitoring arrangements in place to oversee the delivery and progression of medical job planning, rostering, annual leave and sickness management, to ensure achievement of the anticipated improvements.	7,8 and 9



7.12 Alcohol Standards Follow-up



Assurance Not Applicable

Purpose

We have completed a second follow-up review of 'Alcohol Standards'.

Our original Implementation of Alcohol Standards audit was reported in January 2024 and identified seven issues and resulted in an overall assurance rating of 'Limited Assurance'.

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

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

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

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

Overview

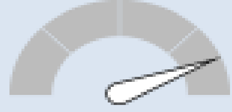
Our follow up review has confirmed that all three agreed actions have been **implemented**, as follows:

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	1	1	0	0
Medium	2	2	0	0
Total	**3**	**3**	**0**	**0**

As part of our follow-up review, we met with the Executive Director of Public Health and the Consultant in Public Health Medicine to establish the progress that has been made with the implementation of the agreed actions. We then obtained and reviewed documentation and evidence to validate the stated position for each of the actions.

As noted above, this has enabled us to confirm that all the agreed management actions have been implemented. There are now regular meetings being undertaken for the EU Alcohol Screening Project and a quarterly Alcohol Harm Prevention Group has also been established with attendance from CBs. In addition, the Alcohol Brief Intervention Online Training has been promoted within the Cardiff and Vale Public Health Team Newsletter for all staff.

7.13 Decarbonisation Follow-up



Assurance Not Applicable

Purpose

We have completed a follow-up review of the implementation of the agreed management actions from our decarbonisation audit that was issued in June 2024. This follow up review was completed in line with the 2025/26 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

In our original report we identified five matters arising which led to us issuing a 'limited' assurance opinion. We made two high, four medium and one low priority recommendations. Management agreed on actions to address the matters arising and the associated recommendations.

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

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

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

Overview

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

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	2	1	0	1
Medium	4	3	0	1
Low	1	1	0	0
Total	**7**	**5**	**0**	**2**

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

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	Limited	September
Deprivation of Liberties Safeguards (DoLS)	16	Nursing	1/2		Final Report	Reasonable	November
GMS Unified Contract Assurance Framework	28	Chief operating Officer	2/3		Final Report	Substantial	February
ALN Act	08	Allied Health Professionals	3		Final Report	Reasonable	February
Medical Equipment & Devices	09	Allied Health Professionals	2/3		Final Report	Reasonable	February
Standards of Business Conduct	02	Corporate Governance	3/4		Final Report	Reasonable	February
Children and Women Clinical Board Governance and Financial Arrangements	25	Chief Operating Officer	2		Final Report	Reasonable	February
Financial Sustainability – Temporary Staffing Controls	10	Finance	2		Final Report	Reasonable	February
Quality & Safety Governance	34	Chief Exec / Chairman	1		Final Report	Advisory	February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Implementation of Health Roster Follow-up	15	Nursing	2/3		Final Report	N/A	February
Digital Literacy	07	Digital Health & Intelligence	2/3		Final Report	Advisory	May
Clinical Board Adherence to the Managing Attendance at Work Policy	18	People & Culture	1/2		Final Report	Limited	May
Medical Staff Deployment	31	Medical	1		Final Report	Advisory	May
Staff Overpayments	11	Finance / People & Culture	3		Final Report	Limited	May
Alcohol Standards Follow-up	03	Public Health	4		Final Report	N/A	May
Risk Management and Board Assurance Framework	01	Corporate Governance	4		Final Report	Reasonable	May
Decarbonisation Follow-up	12	Finance	4		Final Report	N/A	May
Neurodevelopment Services - Children	27	Chief Operating Officer	4		Final Report	Reasonable	May
Occupational Health	20	People & Culture	3		Final Report	Substantial	May
Neurodevelopment Services – Adults	27	Chief Operating Officer	4		Final Report	Limited	May
Nurse Staffing Levels	17	Nursing	4		Final Report	Reasonable	May
5 Steps to Safer Surgery	33	Medical	2/3	4	Draft Report	Reasonable	Sept 26
Local / Shadow IT Systems	06	Digital Health & Intelligence	4		Draft Report	Reasonable	Sept 26
Leadership and Management Training / Development	19	People & Culture	3/4		Draft Report	Reasonable	Sept 26
Estates Assurance – Space Utilisation	14	Finance	2		Work in Progress		Sept 26

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reducing Health Inequalities	22	Public Health	3		Work in Progress		Sept 26
Medicines Management	32	Medical	3/4		Work in Progress		Sept 26
Follow-ups not booked	30	Chief operating Officer	2	3	Work in Progress		Sept 26
Flexible Working Arrangements for Compressed and Variable Hours	36	COO / People & Culture	4		Work in Progress		Sept 26
Approved Integrated Audit & Assurance Plan Assignments:							
Rhydlafar Development	SSU	Finance	4		Final Report	Reasonable	May
Wellbeing Hub at Park View	SSU	Finance	2		Final Report	Reasonable	May

Reviews removed from the plan

CD&T CB – Governance Arrangements	24	Chief Operating Officer	Replaced by advisory review of Quality & Safety Governance. Agreed by September AC.
Diabetes Care Process	23	Public Health	Deferred from the 25/26 plan due to the ongoing introduction of new processes. Agreed by November AC.
Performance Management	29	Chief operating Officer	Proposed for deferral due to planned changes in the CB performance reporting ahead of the organisational re-design. To be agreed by May AC.
Interventions Not Normally Undertaken Follow-up	21	Public Health	Proposed for deferral due to due to changes in lead manager and Exec. To be agreed by May AC.
AI – Use of Robotics and Automation	05	Digital Health & Intelligence	Proposed for deferral due to overlap with the scope of the Audit Wales Deep Dive into Digital. To be agreed by May AC.
Planned Care Programme	26	Chief Operating Officer	Proposed for deferral due to an overlap with the scope of the recent Audit Wales review. To be agreed by May AC.

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Cyber Security	Limited	Final	04/08/25	26/08/25	14/08/25	15/08/25	G
Integrated Annual Plan	Reasonable	Final	25/07/25	15/08/25	15/08/25	18/08/25	G
Medicine Clinical Board – Acute Medicine Model	Reasonable	Final	07/08/25	29/08/25	20/08/25	20/08/25	G
Deprivation of Liberties Safeguards	Reasonable	Final	19/08/25	10/09/25	10/09/25	10/09/25	G
ALN Act	Reasonable	Final	10/11/25	01/12/25	01/12/25	02/12/25	G
Medical Equipment & Devices	Reasonable	Final	28/10/25	18/11/25	08/12/25	09/12/25	R
Standards of Business Conduct	Reasonable	Final	09/12/25	02/01/26	17/12/25	17/12/25	G
Children and Women Clinical Board Governance and Financial Arrangements	Reasonable	Final	20/11/25	11/12/25	19/12/25	19/12/25	R
Financial Sustainability – Temporary Staffing Controls	Reasonable	Final	15/12/25	08/01/26	21/12/25	22/12/25	G
GMS Unified Contract Assurance Framework	Substantial	Final	14/01/26	04/02/26	21/01/26	21/01/26	G
Quality & Safety Governance	Advisory	Final	07/11/25	28/11/25	14/01/26	21/01/26	R
Implementation of Health Roster Follow-up	N/A	Final	13/01/26	03/03/26	21/01/26	21/01/26	G
Digital Literacy	Advisory	Final	20/01/26	10/02/26	04/03/26	05/03/26	R
Clinical Board Adherence to the Managing Attendance at Work Policy	Limited	Final	12/02/26	05/03/26	04/03/26	05/03/26	G
Medical Staff Deployment	Advisory	Final	05/03/26	26/03/26	25/03/26	27/03/26	G

Staff Overpayments	Limited	Final	05/03/26	26/03/26	25/03/26	30/03/26	G
Alcohol Standards Follow-up	N/A	Final	05/03/26	26/03/26	26/03/26	30/03/26	G
Risk Management & Board Assurance Framework	Reasonable	Final	09/04/26	30/04/26	17/04/26	20/04/26	G
Decarbonisation Follow-up	N/A	Final	22/04/26	14/05/26	27/04/26	27/04/26	G
Neurodevelopmental Services – Children	Reasonable	Final	23/03/26	15/04/26	27/04/26	27/04/26	R
Occupational Health Services	Substantial	Final	23/04/26	15/05/26	28/04/26	28/04/26	G
Rhydlafar Development	Reasonable	Final	20/03/26	14/04/26	24/04/26	01/05/26	R
Neurodevelopmental Services – Adults	Limited	Final	23/03/26	15/04/26	30/04/26	01/05/26	R
Wellbeing Hub at Park View	Reasonable	Final	12/03/26	02/04/26	01/05/26	01/05/26	R
Nurse Staffing Levels	Reasonable	Final	22/04/26	14/05/26	02/05/26	05/05/26	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	May 2025	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	A	63% 19 from 30	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 28 from 28	95%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	68% 17 from 25	85%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 25 from 25	95%	v>20%	10%<v< 20%	v<10%

ASSURANCE ON RECOMMENDATION TRACKING

Audit Information			Validation Process	
Audit Title	**Finding**	**Rating**	**Internal Audit validation result**	**Basis of validation**
Medical Equipment and Devices (CVU 2223-24) Final Report Issued: October 2022 Rating: Reasonable Assurance	4. Accuracy of equipment location	Medium	Complete	Evidence of completion confirmed as part of our Medical Equipment audit in 2025/26.
	7. Evidence of training	Medium		
Alcohol Standards (CVU 2324-21) Final Report issued: January 2023 Rating: Limited Assurance	1. Guidance	High	Complete	Evidence of completion confirmed as part of our Alcohol Standards second Follow-up audit in 2025/26.
	2. Screening Tool	High		
	3. Resources in the team	High		
	4. Referral Process	High		
	5. Training	High		
	6. Documentation for patients	High		
	7. Intervention Pathway	Medium		
Business Continuity Planning (CVU 2425-07) Final Report Issued: April 2025 Rating: Reasonable Assurance	3. Risk Register	Medium	Complete	Evidence received from Emergency Preparedness, Resilience and Response (EPRR) Manager.

Audit Information			Validation Process	
Audit Title	**Finding**	**Rating**	**Internal Audit validation result**	**Basis of validation**
Implementation of Health Roster Follow-up (CVU 2425-07) Final Report Issued: January 2025 Rating: Limited Assurance	4. Auto-rostering functionality	Medium	Complete	Evidence of completion confirmed as part of our Implementation of Health Roster second Follow-up audit in 2025/26.
Decarbonisation (CVU 2324-19) Final Report Issued: June 2024 Rating: Limited Assurance	1.1 Terms of reference	Medium	Complete	Evidence of completion confirmed as part of our Decarbonisation Follow-up audit in 2025/26.
	1.2 Meetings	Medium		
	2. Risk of not meeting carbon reduction targets	High		
	3. Training	Medium		

Assurance Ratings

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

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Report Title:	Internal Audit Plan 2026/27			Agenda Item no.	2.2	
Meeting:	Audit & Assurance	Public	X	Meeting Date:	19/05/26	
		Private				
Status:	Assurance		Approval	X	Information	X
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.

It is a requirement of the Global Internal Audit Standards that an Internal Audit Plan and Charter is prepared on an annual basis and presented to the Audit Committee for approval.

The work undertaken by Internal Audit will be completed in accordance with the Plan, which has been prepared following a detailed planning process and is subject to Audit and Assurance Committee approval. The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards.

The Internal Audit Mandate and Charter has been updated as at March 2026 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

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

The Internal Audit plan for 2026/27 has been developed following review of the Health Board's key objectives, Corporate Risk Register, Board Assurance Framework, relevant Committee papers, previous audits undertaken and other key papers and documents.

Individual planning discussions were held with each of the Executive Directors, the Chief Executive, Chair, and Audit & Assurance Committee Chair to inform development of the plan.

An initial version of the draft plan was shared with the Strategic Leadership Team for review and comment, and to inform prioritisation of the potential audits to ensure that the plan can be delivered within the available resources.

The plan covers the whole of the 2026/27 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Board's evolving risks and changing priorities and therefore provide effective assurance.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Approve** the Internal Audit Plan for 2026/27;
- **Approve** the Internal Audit Mandate and Charter; and
- **Note** the associated Internal Audit resource requirements and Key Performance Indicators.

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

1.		2.	

Click the objective above to view more detail.		**Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?					
Yes		No	x	Not Required	

Impact Assessment:
Risk: Yes/~~No~~ (delete as appropriate)
Development and delivery of the Internal Audit plan provides the Health Board with a level of assurance around the management of a series of risks covered within the specific audit assignments.
Safety: Yes/~~No~~
The Annual Plan includes audits that will provide assurance around controls and processes relating to patient safety.
Financial: Yes/~~No~~
The Annual Plan includes audits that will provide assurance around financial controls and processes.
Workforce: Yes/~~No~~
The Annual Plan includes audits that will provide assurance around controls and processes relating to Workforce.
Legal: Yes/~~No~~
The Annual Plan includes audits that will provide assurance around legal controls and processes.
Reputational: Yes/~~No~~
The Annual Plan includes audits that will provide assurance around reputational risks.
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~~
The Annual Plan includes audits that will provide assurance around controls and processes relating to equality and health.
Decarbonisation: ~~Yes~~/No
Welsh Language: ~~Yes~~/No

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

Internal Audit Plan 2026/27

Cardiff and Vale University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by the Health Board's management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the corporate risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).
6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of the Health Board's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit and Assurance Committee, the Quality Committee and the Finance and Performance Committee).
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit and Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

The audit of major capital programmes / projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective business cases approved and funded by Welsh Government.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
1. Risk Management / Board Assurance Framework Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	IA / Exec / BAF	Corporate Governance	Q4
2. Speaking Up Safely Review of the effectiveness and operation of the Health Board's processes for speaking up safely and the raising of staff concerns. Include a focus on the publicity and awareness of the processes across the Health Board.	IA	Corporate Governance	Q1
3. Regulatory and Legislative compliance Review of the processes for recording, managing and reporting compliance with regulatory / legislative requirements and other communications.	IA	Corporate Governance	Q2
4. Escalation Status Governance / Actions Review of the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and de-escalation actions.	IA / Exec / BAF Sustainability	Strategy, Planning and Partnerships / Finance	Q2/3
5. Budget Setting To review how the Health Board sets delegated budgets to meet its agreed financial plan, and the ongoing management of the delegated budgets.	IA / Exec / BAF Sustainability	Finance	Q2

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
6. Charitable Funds Review the processes in place within the Health Board to ensure that Charitable Fundraising is appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.	IA / Exec	Finance	Q1/2
7. Estates Assurance General provision of time for an Estates Assurance audit. Coverage and scope of the audit to be agreed. *Potential coverage could include any areas coming out of the Audit Wales review of the arrangements to Manage Estates, or a review of the Health Board's Condition Survey work.*	IA / Exec / BAF Infrastructure	Finance	TBC
8. CB Adherence to the Managing Attendance at Work Policy Follow-up Follow-up of 25/26 Limited Assurance audit to determine progress with the implementation of the agreed management actions.	IA / Follow-up / BAF	People & Culture	TBC
9. Staff Overpayments Follow-up Follow-up of 25/26 Limited Assurance audit to determine progress with the implementation of the agreed management actions.	IA / Follow-up / BAF	People & Culture / Finance	TBC
10. Staff Rostering Review how the Health Board is utilising the Health Roster system to ensure effective and timely rostering across the various staff groups including nursing, AHPs, Health Scientists and Estates.	IA / Exec / BAF People	People & Culture / Relevant Staff Group Executives	Q1/2

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
11. Workforce Planning Review of the Health Board's longer-term workforce planning arrangements covering the next 3 to 5 years.	IA / Exec / BAF People	People & Culture	Q2
12. People & Culture Strategic Development Review of how the Health Board is taking forward its strategic plans around improving people and culture, including the refresh of the People & Culture Plan and implementation of the Shaping Our Future People and Culture portfolio Board.	IA / Exec / BAF People	People & Culture	Q3
13. Medical staff deployment Assurance Audit Provision of time for an assurance audit on medical staff deployment, potentially covering job panning / rostering / annual leave. *The exact scope of the audit will be informed by the outcome of our advisory audit of medical Staff deployment which is due to report in March 2026.*	IA / Exec / BAF People	Medical	Q3/4
14. Clinical Audit To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Clinical Audit.	IA / Exec / BAF Quality	Medical	Q2/3
15. INNU follow-up (Deferred from 25/26 plan) Follow-up of 24/25 Limited Assurance audit to determine progress with the implementation of the agreed management actions.	IA / Follow-up	Medical	TBC

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
16. Quality Management System Review of the ongoing development and implementation of the Health Board's Quality Management System, following on from our advisory 2025/26 review of Quality & Safety Governance.	IA / Exec / BAF Quality	Nursing / Medical	Q3/4
17. Clinical Safety Groups Review of the structure, function, operation and governance arrangements in place for the Health Board's Clinical Safety Groups.	Exec / BAF Quality	Nursing	Q1/2
18. Infection Prevention & Control Assess the controls in place for the management of key systems and risk areas in relation to infection prevention and control. To include a review of the utilisation of the Beacon Dashboard, as agreed with the Medical Director.	IA / BAF Quality	Nursing	Q3
19. Nationally Reportable Incidents (NRIs) Review the processes in place for the identification, recording and reporting of NRIs to ensure compliance with Putting Things Right timescales, and the arrangements for investigation and learning to ensure quality improvement and improved patient safety.	Exec / BAF Quality	Nursing	Q2/3

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
20. Diabetes 8 Care Processes (Deferred from 25/26 plan) Review of the processes for ensuring completion of the required 8 annual checks for all diabetes patients, in accordance with NICE guidance.	Exec / BAF Health Inequity	Public Health / Chief Operating Officer	Q1/2
21. CD&T CB – Governance Arrangements Review of the structure and Governance arrangements within the Clinical Board. To include review of the processes around financial management, budgetary control, and development and delivery of savings.	IA / Exec	Chief Operating Officer	Q2
22. Medicine CB – Governance Arrangements Review of the structure and Governance arrangements within the Clinical Board. To include review of the processes around financial management, budgetary control, and development and delivery of savings.	IA / Exec	Chief Operating Officer	Q3
23. Radiology Staff Rotas Review of the processes and procedures in place for the management of staff rotas within the Radiology service.	Exec / BAF People	Chief Operating Officer / Therapies and Health Sciences	Q1
24. Endoscopy Review of structures, governance processes and waiting list management.	Exec / BAF Quality	Chief Operating Officer	Q1/2

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
25. Planned Care (Deferred from 25/26 plan) Potential review of compliance to best practice recommendations. *Exact scope to be agreed with Deputy Chief Operating Officer*.	IA / Exec / BAF Quality	Chief Operating Officer	Q2/3
26. Primary Care Services Potential audit of an element of contractor services. Detail of the element to be confirmed by the Director of Operational Planning & Performance and the Primary Care team.	IA / Exec / BAF Health Equity	Chief Operating Officer	Q3/4
27. Cyber Security Follow-up Follow-up of 25/26 Limited Assurance audit to determine progress with the implementation of the agreed management actions.	IA / Follow-up / BAF Digital	Digital & Health Intelligence	TBC
28. AI – Use of Robotics and Automation (Deferred From 25/26 plan) Review how the Health Board is developing and delivering a governance structure around the use of AI.	IA / Exec / BAF Digital	Digital & Health Intelligence	Q1/2
29. Telecoms Review the governance, controls, value and coordination of the provision of telecoms functionality within the health board.	Exec	Digital & Health Intelligence	Q2/3

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
30. Digital Systems Uptake and Utilisation Review the level of uptake and utilisation of digital systems once they have been introduced and the subsequent realisation of benefits.	IA / Exec / BAF Digital	Digital & Health Intelligence	Q3
31. ALAS Equipment Purchasing and Stock Management Review of the processes within the Artificial Limb and Appliance Service (ALAS) for the purchasing of equipment and management of stock.	Exec	Therapies and Health Sciences	Q1
32. Audiology Referral and Waiting List Management Review of the processes within the Adult and Children's Audiology services for the management of referrals, waiting lists and follow-up appointments.	Exec	Therapies and Health Sciences	Q1
33. Tracking of improvements following reviews Review of the processes in place for recording, tracking and reporting actions identified from internal or external reviews, to provide assurance that required improvements are being delivered.	Exec	Chief Executive	Q4
34. Demand & Capacity Modelling Review of the adequacy and effectiveness of the Health Board's arrangements for demand and capacity modelling, including whether these arrangements are supporting safe, sustainable and value-based service delivery.	IA / Exec	Strategy, Planning and Partnerships	Q1/2

Planned output, Outline scope, Review reference	Strategic Priority / BAF Risk / Corporate Risk Register (CRR) / Rationale	Executive Lead/Responsible Director	Planned start
35. Development of the Clinical Services Plan Review of the ongoing processes for developing the Health Board's Clinical Services Plan, including staff and public engagement.	IA / Exec / BAF Sustainability	Strategy, Planning and Partnerships	Q1/2
36. Strategic planning Infrastructure Review of the strategic planning infrastructure in place within the Health Board, including the structure and resourcing of the Planning team. To include benchmarking against the infrastructure within other NHS Wales organisations.	IA / Exec	Strategy, Planning and Partnerships	Q3/4
Capital Projects The audit of major capital programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective business cases approved and funded by Welsh Government.	IA / Exec / BAF Infrastructure	Finance	

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2025/26 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	80%
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	85%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Cardiff and Vale University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit & Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Cardiff and Vale University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
- the appropriate assessment and management of risk, and the related system of assurance.
- the arrangements to monitor performance and secure value for money in the use of resources.
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit & Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit & Assurance Committee on behalf of the Board. Such functional reporting includes the Audit & Assurance Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity’s performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit & Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit & Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit & Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit & Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit & Assurance Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit & Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit & Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk & Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned.
- reviewing specific operations at the request of the Audit & Assurance Committee or management, this may include areas of concern identified in the corporate risk register.
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
- reviewing the Annual Governance Statement prepared by senior management.

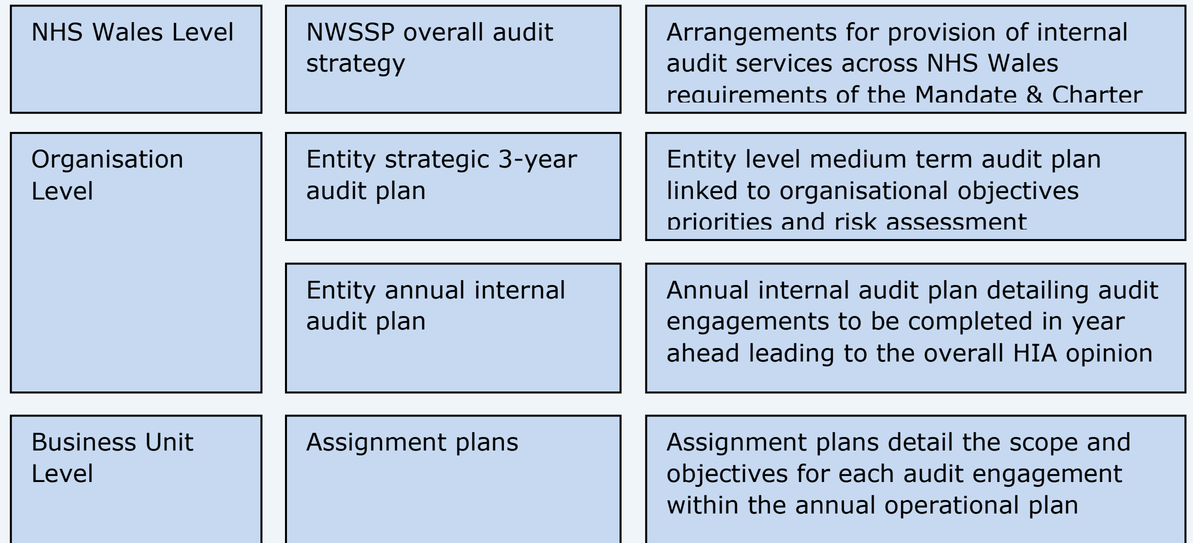
7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit & Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy



8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit & Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit & Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
  b) Disclose any qualification to that opinion, together with the reasons for the qualification.
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit & Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit & Assurance Committee requirements; and
- The Audit & Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit & Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit & Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director

of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit & Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit & Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit & Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit & Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2026

Disclaimer

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

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

Global 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. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

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

Date issued: May 2026

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Introduction

This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in May 2026.

We also provide additional information on:

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

Accounts audit update

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

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Draft accounts received 1 May 2026. Audit work ongoing
- **Expected committee date:** June 2026

Audit of the 2025-26 Health Charities Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2025-26 Health Charities Annual Report and Accounts
- **Status:** Planning work commenced. Audit to take place in Autumn 2026.
- **Expected committee date:** January 2027 (Board of Trustees)

Performance audit update

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

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work examined digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Draft report issued to the Health Board in April for clearance
- **Expected committee date:** September 2026

Progress review: 2019 Clinical Coding Follow-up Review

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work focused on reviewing the Health Board's progress in addressing the recommendations made in our 2019 clinical coding follow-up review, which was a follow-up of the work completed in 2014.
- **Status:** Draft report issued to the Health Board in March for clearance
- **Expected committee date:** September 2026

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

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

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work follows on from the review of national leadership arrangements for cancer services. It examines whether the Health Board is taking the necessary action to provide timely and equitable access to cancer diagnosis and treatment, in line with national targets, standards and plans.
- **Status:** Fieldwork in progress
- **Expected committee date:** September 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations. It will also inform our thinking on whether to undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).
- **Status:** Planning
- **Expected committee date:** February 2027

Review of the management and prevention of diabetes

- **Executive Lead:** Executive Director of Public Health
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. The exact focus of this work is still to be determined, but it will focus on the ambitions set out in the Tackling Diabetes Together Programme, and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.
- **Status:** Planning
- **Expected committee date:** May 2027

Operating Theatre efficiency and effectiveness

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will focus on the management of operating theatres and the extent to which arrangements support efficient, effective and good quality services.
- **Status:** Planning
- **Expected committee date:** To be confirmed

Other relevant publications

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

Publication	Date
Additional Learning Needs: Do public bodies know if the system is working? / Data tool / Article	April 2026
Managing the Regional Integration Fund Report / Article	March 2026
Auditor General's letter to Senedd committees	March 2026
Senedd nominates Catherine Mealing Jones for appointment as next Auditor General for Wales	March 2026
Private Finance – Public Impact (Examining decision-making for the new Velindre Cancer Centre	February 2026

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

Strategic Equality Plan 2026-30	April 2026
Annual Plan for 2026-27	April 2026

There are no relevant Audit Wales consultations currently underway.

Further information

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

Visit our website to find:

Our publications which cover our audit work at public bodies.

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

Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

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

Audit Wales

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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.

Cardiff and Vale University Health Board – Audit Plan 2026

Date issued: March 2026

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Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my 2026 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 21) sets out how we will ensure those standards of quality are met. Our latest annual audit quality report provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

Assure people that public money is being managed well

Explain how that money is being spent

Inspire the public sector to improve

Our vision

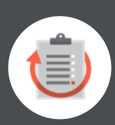
Fully exploiting our unique perspective, expertise and depth of insight

Strengthening our position as an authoritative, trusted and independent voice

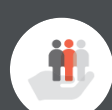
Increasing our visibility, influence, and relevance

Being a model organisation for the public sector in Wales and beyond

Our areas of focus


A strategic, dynamic, and high-quality audit programme

A targeted and impactful approach to communications and influencing


A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2025-26 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting standards and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

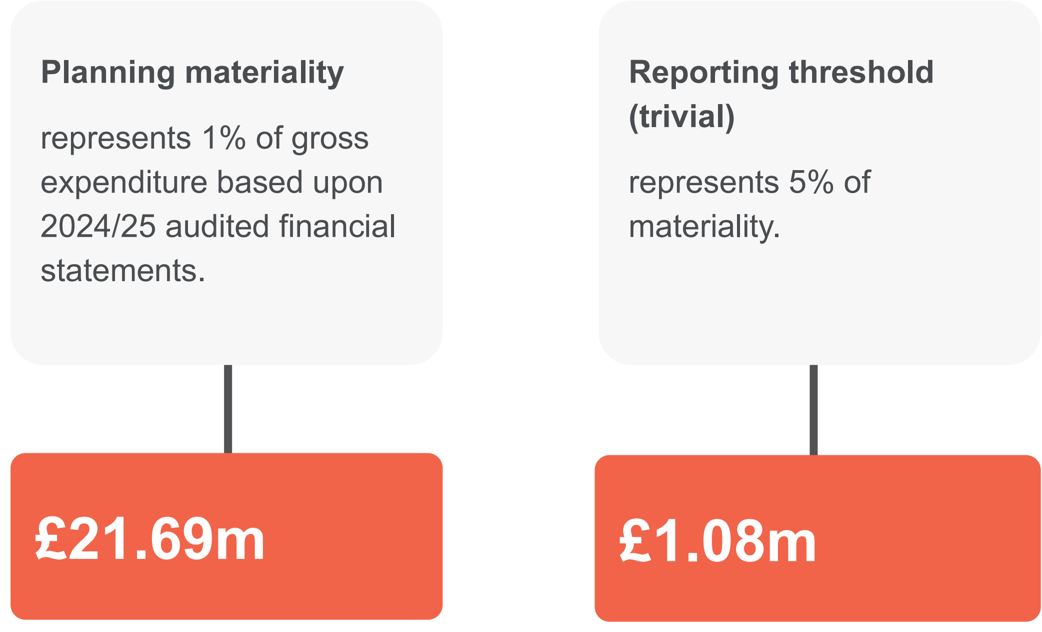
I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.



There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk.

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Failure of first financial duty

There is a significant risk that you will fail to meet your first financial duty to break even over a three-year period. The position at month 11 shows a year-to-date deficit of £51.6m and a forecast year-end deficit of £56.2m. This, combined with the outturns for 2023-24 and 2024-25, predicts a three-year surplus/deficit of £95.6m.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Our planned response

My audit team will:

- monitor the Health Board’s financial position for 2025-26 and the cumulative three-year position to 31 March 2026.

- Consider the cumulative impact of any relevant uncorrected misstatements over the three years to 31 March 2026.

Risk of fraud in capital expenditure recognition

There is a risk of material misstatement due to fraud in capital expenditure recognition and as such is treated as a significant risk.

As at month 11, the Health Board has spent 40% of its capital budget and is forecast to break even and meet its Capital Resource Limit (CRL). There is a risk that capital expenditure in month 12 could be misclassified or included in the wrong period.

Our planned response

My audit team will:

- perform detailed testing on a sample of additions and capital accruals to ensure they are correctly classified and included in the correct period.
- assess the design and implementation of controls in relation to capital expenditure recognition.

Remuneration report disclosures

There have been several new permanent and interim appointments to senior officer and board member posts during 2025-26 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature. We have also previously identified material issues with these disclosures.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

There is also a regularity risk if payments are made without appropriate Welsh Government approval.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2025-26;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2026.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;

- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- where material, test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Health Board and the other body/party.

The Health Board has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature.

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- Review management's estimation process for the valuation of provisions;
- Consider the competence, capability and objectivity of the management experts who are prepare the estimates; and
- Ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Phase	Activities
Planning & Interim **January to April 2026**	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing Indicative audit fee Draft Audit Plan
Fieldwork **May to June 2026**	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting **June 2026**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru
Post Certification **July 2026**	Annual audit summary Post project learning

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

Strategic planning

Asset management

Financial planning

Collaborative working

Performance and risk management

Overall governance.

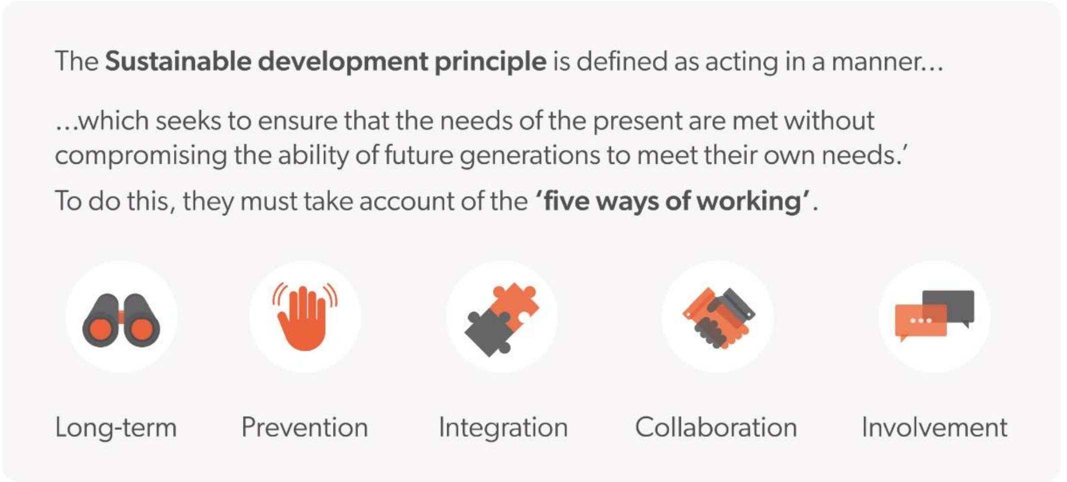
Workforce planning

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my planned performance audit work.

Structured Assessment

Scope of the work

Structured assessment will continue to form a key part of the audit work my audit teams do at each NHS body.

My 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources.

This work will also review how the audited body tracks progress against previous audit recommendations. This helps the audit team check that improvements identified in earlier audits are being addressed. It also helps us measure the impact of our work more clearly.

My 2026 Structured Assessment work will also inform our thinking on whether we should undertake future work on hosted b

odies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

All-Wales thematic review of the management and prevention of diabetes

Scope of the work

I plan to undertake work to examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. Whilst the exact focus of this work is still to be determined, it will focus on the ambitions set out in the Tackling Diabetes Together Programme, and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes. Indicative timescales

Fieldwork to commence between September and October 2026 and reporting by the end of March 2027.

Local project work – Operating Theatre efficiency and effectiveness

Scope of the work

My audit team will also undertake performance audit work that reflects issues specific to the Health Board. The local performance audit work will focus on the management of operating theatres and the extent that arrangements support efficient, effective and good quality services.

Indicative timescales

We will discuss the delivery timescales with senior management early in the 2026-27 financial year.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and progress will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Based on those requirements, my estimated audit fee for 2026 will be £466,351, an increase of 5.3% on my estimated 2025 fee.

Your estimated total audit fee: £466,351

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Executive Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2026 (and 2025 for comparison)

Estimated fee for 2026 (£)[1]		Estimated fee for 2025 (£)	
Audit of financial statements[2]	Performance audit work[2]	Audit of financial statements	Performance audit work
£273,732	£192,619	£260,061	£182,994
Total fee: £466,351		**Total fee: £443,055**	

[1] The fees shown in this document are exclusive of VAT.

[2] Payable November 2025 to October 2026

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

	Financial Audit	Performance Audit
Engagement Director	Tom Haslam tom.haslam@audit.wales	
Engagement Lead	Gareth Lucey gareth.lucey@audit.wales	Tom Haslam tom.haslam@audit.wales
Audit Manager	Rachel Freitag rachel.freitag@audit.wales	Darren Griffiths darren.griffiths@audit.wales
Audit Lead	Rhodri Davies rhodri.davies@audit.wales	Urvisha Perez urvisha.perez@audit.wales

I can confirm that my team members are all independent of the Health Board and your officers. I am not aware of any potential conflicts of interest that I need to bring to your attention.

Audit quality

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

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

Our People

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

Arrangements for achieving audit quality Selection of right team

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

Independent assurance

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

Further Information

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

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

Data tools to help you better understand public spending trends

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

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

Audit Wales

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E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Report Title:	**Risk Management Update**			Agenda Item no.	2.5	
Meeting:	Audit & Assurance Committee	Public	x	Meeting Date:	19th May 2026	
		Private				
Status	Assurance x	Approval		Information		x
Lead Executive	Director of Corporate Governance					
Report Author	Corporate Archivist and Records Management Manager					

Main Report
Background and current situation:

This report is designed to set out the current position and to provide the Committee with an update and assurance regarding the Health Board's Risk Management status following digital transformation, and the arrangements in place to ensure risks are reviewed, moderated and escalated appropriately.

The Risk Management & Board Assurance Framework Internal Audit (CVU-2526-01) for 2025/26 concluded Reasonable Assurance, confirming that core risk management arrangements are in place and operating effectively, with some areas requiring further strengthening. The audit recognised strong progress in the ongoing implementation of the AMaT risk management system, improved articulation of strategic risks through the Board Assurance Framework, and positive feedback from Clinical Boards on corporate governance support. Fieldwork was completed in March 2026, with Executive sign-off on 16 April 2026.

A total of five management actions were agreed: one high-priority action relating to the size and effectiveness of the Corporate Risk Register, and four medium-priority actions focused on policy documentation accuracy, risk data cleansing, consistency of Clinical Board and sub-committee risk scrutiny, and clearer linkage to the BAF. One action has already been completed, with the remaining actions programmed through September 2026 to March 2027, providing a clear and time-bound improvement plan to further strengthen governance, oversight, and Board assurance.

These findings demonstrate that the Health Board has completed a significant programme of work to digitise and standardise risk management through the implementation of the AMaT Risk Module. This has replaced a fragmented landscape of multiple local Excel-based risk registers with a single, organisation-wide digital repository, providing enhanced transparency, consistency and auditability of risks across Clinical Boards and Corporate Directorates.

As of 28th April 2026, AMaT holds 1,307 active risks across the organisation. These risks are recorded at Local service, Directorate, Clinical Board and Corporate levels within a single system, enabling consistent reporting, monitoring and assurance.

Clinical Board/Directorate	**Total Risks**	**Low to Moderate (1 – 10)**	**High Risk (12-16)**	**Extreme Risks (20-25)**
All Wales Medical Genomics Service	89	78	9	2
Capital Estates and Facilities	431	106	245	80
Children & Women	71	30	35	6
Clinical Diagnostics & Therapeutics	173	59	100	14
Corporate	144	95	38	11
Medicine	66	17	28	21
Mental health	20	7	9	4
Primary, Community & Intermediate Care	83	18	50	15
Specialist Services	80	8	35	37
Surgical	150	100	41	9

Table 1. Risks captured across services

The completion of the digital transition has shifted the organisation from a focus on risk capture to a position where risk quality, ageing and proportional escalation can be more effectively scrutinised. This has highlighted a legacy position whereby some risks have remained open and unchanged for extended periods.

AMaT reporting now enables the identification of risks that have remained active beyond one year, including extreme and high risks, as well as lower-scoring risks that retain a high likelihood rating despite relatively low impact.

Risk rating	Count
Almost Certain / Catastrophic / 25	13
Almost Certain / Major / 20	50
Highly Likely / Catastrophic / 20	57

Table 2. Count of Extreme risks (score 20–25) which remain open beyond 12 months

Risk rating	Count
Almost Certain / Minor / 10	1
Highly Likely / Minor / 8	12
Highly Likely / Negligible / 4	1

Table 3. Count of Low–moderate risks (score 4–10) that continue to be scored as *Highly Likely* or *Almost Certain* despite relatively low impact, and which have remained open for over a year

The presence of long-standing risks does not in itself indicate unmanaged risk. However, it does require assurance that likelihood, impact, mitigating controls and risk trajectory remain valid and subject to appropriate challenge.

Appendices (located in the supporting documents folder):

1. Corporate Risk Register

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

Two years ago we had a disparate, unautomated, opaque system of risk management that was captured across in excess of 70 risk registers held locally that did not speak to each other and from which no usable information could be obtained.

With the national work on a digital system making no progress the decision was made to engage with the owners of the AMAT software already being used in the HB and together we have developed a new risk module with them.

The work that followed, coordinated by a task and finish group comprising representatives of all CBs and Directorates, has achieved a significant data transfer of around 1,500 risks to the single system, and subsequently reduced to 1,307 as work is undertaken to review and moderate the risks.

That task and finish group has now changed to a standing Organisational Risk Management Group. This group will drive the actions identified in the recent audit – further moderation, data cleansing and review to continue to improve the value of the data contained within the system.

But the purpose of the risk management system is not simply to have the best possible data, it is about how it is used. Concurrently, work is taking place to ensure those who need to be using the information have the ability to pull out the information that they need. Specifically, these include:

- Clinical board reviews – ensuring that CBs are highlighting, in a consistent format, the key risks they hold to Executives so that action, deconfliction, alignment etc can be undertaken. Key risks will be discussed in the May CB reviews.

- Quality Management System. The Quality Committee is evolving as part of this work and work is underway to ensure that the Clinical Safety Group, which brings together all CBs within the QMS, has the ability to extract and analyse the key quality risks and respond and coordinate accordingly.

- Strategic Leadership Team. The group will drive moderation across each CB/Directorate to the point that SLT will conduct a whole organisation moderation in Q3. Again, the point is to inform decision making, resource allocation and strategic direction.

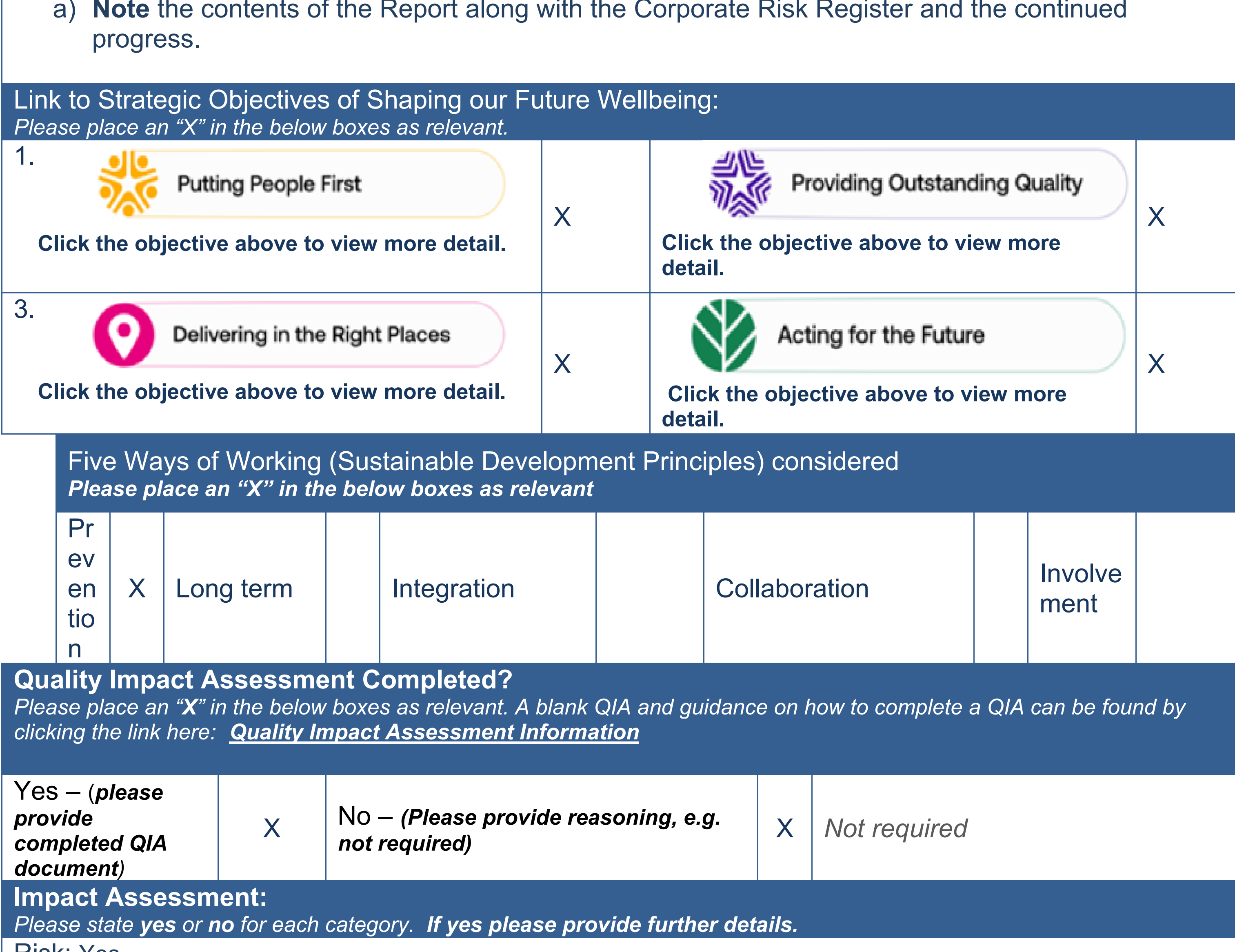
and this work will extend to augment work in other areas such as cultural review and prediction activity.

Following the moderation work driven by the ORMG and that will take place at SLT, the corporate risk register will be presented to the Audit Committee for discussion at the next risk update in November 2026. The current Corporate Risk Register is at the appendix as a baseline for comparison.

Recommendation:

The Committee are requested to:

a) **Note** the contents of the Report along with the Corporate Risk Register and the continued progress.



Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "X" in the below boxes as relevant.

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

Five Ways of Working (Sustainable Development Principles) considered
Please place an "X" in the below boxes as relevant

Prevention	X	Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?
*Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***

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

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

Risk: Yes

The management and maintenance of the Health Board's Risk Register contributes to the Health Board's Risk Management processed and procedures.

Safety: No

Financial: /No

Workforce: No

Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	**Management of Health Board Policies**				Agenda Item no.	2.5
Meeting:	Audit and Assurance Committee		Public	X	Meeting Date:	19th May 2026
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Corporate Archivist and Records Management Manager					

Background and current situation:

The Corporate Governance Team coordinates the development, publication, and archiving of Cardiff and Vale University Health Board Policies and other controlled documents. Internal Audit identified several opportunities to enhance the policy management framework during a Policy Audit conducted in March 2023, which initially resulted in a limited assurance rating. In response, the team has implemented a series of improvements, including advancing digitalisation efforts. These actions led to a reassessment in May 2024, where the assurance status was upgraded to reasonable assurance, reflecting positive progress in the management and oversight of Health Board policies

This paper sets out the progress and work undertaken around policy management by the Corporate Governance Team since the findings and sets out the current position.

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

Control Documents Update

The following control documents are in place to manage Policies and other written control documents in the organisation:

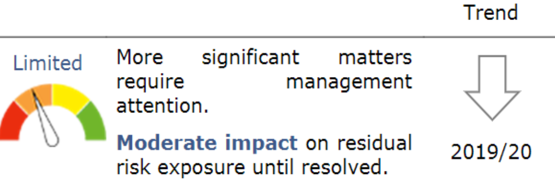
UHB 001 (Management of Policies, Procedure and other Written Control Documents Policy)
Updated Sep 2024 with further review scheduled 2027

UHB 242 (Written Control Documents – Development and Approval Procedure).
Updated Dec 2025 with further review scheduled 2028

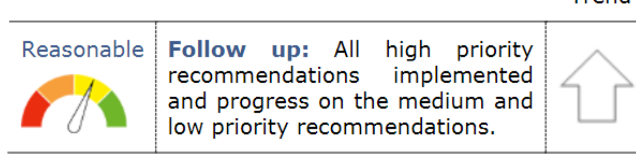
Internal Audit outcome

The Health Boards control status was raised from Limited Assurance to Reasonable Assurance in May 2024 for the Management of Health Board Policies. This was a positive improvement largely due to a number of ongoing actions being resolved and the switch to an automated system to track each policies review date, which is summarised further below.

2023 Audit findings
9 key findings identified. All actions are complete.



2024 Audit findings
3 key findings identified. All actions are complete.



Key actions taken to improve Policy Management:

Amendments to UHB 001 and UHB 242 documents were a necessary step in the improvement of controlled document management and were consistent with recommendations made in the original audit

Introduction of AMaT (Audit Management and Tracking) system hosting all Policies, moving the Health Board away from utilising static excel sheets as its catalogue repository.

AMaT has allowed us to host the whole policy catalogue, all relevant information on ownership, version control etc. and enable automated notification reminders to policy owners regarding upcoming expiry dates. This provided assurance that policy owners and authors were being identified and assigned, along with increased controls, transparency and access.

Policy Review Rates

Since the Limited Assurance findings, the Health Board has continued to strengthen its policy management approach, although the overall proportion of overdue reviews has remained broadly stable. There is now greater grip and control over policy management; however, as additional policies are brought into the system and existing ones reach their review dates, the overdue position remains a continually moving picture that requires ongoing oversight.

The increase in total policy numbers reflects improved awareness of the process and more consistent submission to Corporate Governance, recognising that many policies were not previously held within a central repository, alongside the review and resubmission of existing documents. This has resulted in over 150 policies now reviewed and assigned forward review dates between 2027 and 2029, demonstrating tangible progress in establishing structured oversight and longer-term management.

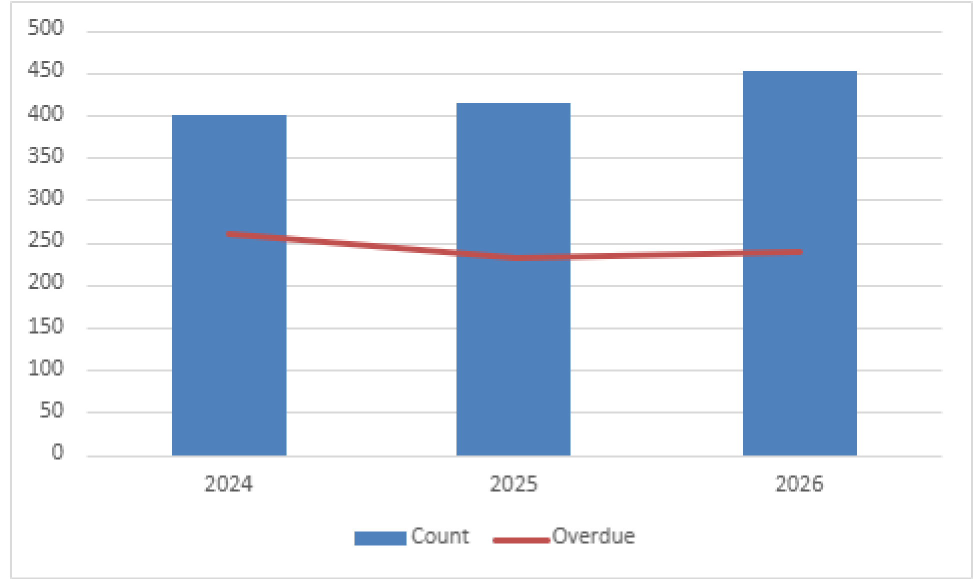


Chart 1 Year on year count of policies held centrally vs volume overdue

This position reflects an increasingly active and maturing process, rather than a static one, with a larger volume of policies now formally tracked and scheduled. Corporate Governance continues to provide regular breakdowns and status summaries to Clinical Board Reviews, supporting transparency and enabling ongoing scrutiny of performance and emerging trends.

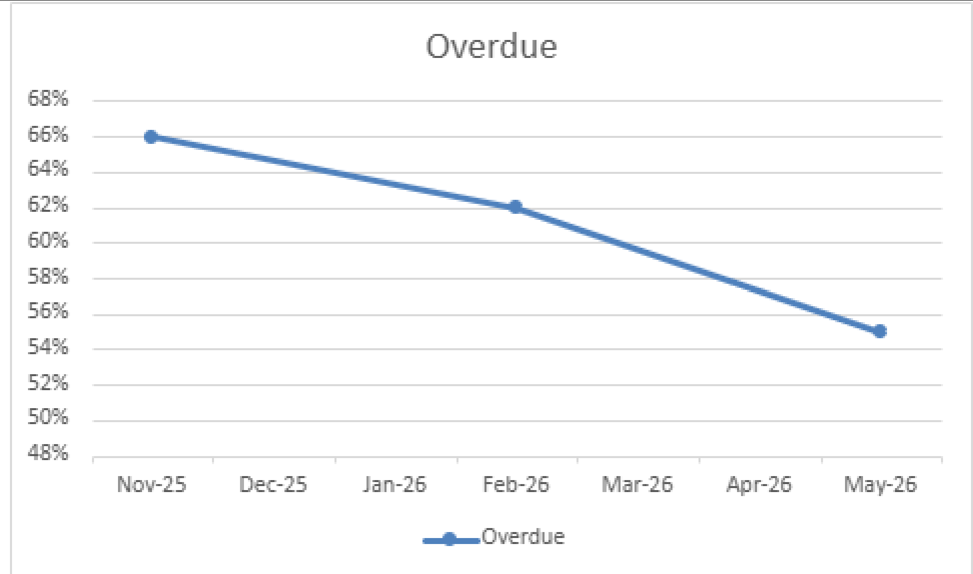


Chart 2 Figures supplied at Clinical Board Reviews

As illustrated in the graph, Clinical Board figures from November 2025, February 2026, and those presented in this report highlight the inherently dynamic nature of policy management; while the year-on-year overdue position remains around 60%, month-to-month performance fluctuates between approximately 50% and 65% as policies approach, reach, and are revised beyond their review dates in bulk.

Recent Improvements in Policy Management

Enhancements have been introduced to further strengthen policy management within the Health Board. The AMaT (Audit Management and Tracking) system now records Clinical Board ownership in addition to the Policy Lead, providing clearer accountability and oversight across all policies. Furthermore, SharePoint pages have been improved to feature easy-read flowcharts, comprehensive tables, and step-by-step process guides. Dedicated help pages have been designed specifically for both the policy creation/consultation phase and for ongoing Policy Reviews, making the process more user-friendly and accessible.

Future Actions

Ongoing enhancements will be made to both SharePoint and the Corporate Governance website to improve usability and access to policy information.

Continued monitoring and direct follow-up of policies approaching review dates will be prioritised, especially as a further 40 policies are due for review between May and December 2026.

Corporate Governance will maintain regular data reporting and provide detailed policy counts and status updates to Clinical Board Reviews, with sessions scheduled for July 2026 and November 2026.

Recommendation:

The Committee are requested to:

a) **Note** the contents of the Report.

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

1. **Click the objective above to view more detail.**

2.

		Click the objective above to view more detail.	
3. Delivering in the Right Places 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	X	Long term	X	Integration		Collaboration	X	Involvement	

Quality Impact Assessment Completed?

		No		

Impact Assessment:

Risk: Yes

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

Safety: Yes

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

Financial: No

Workforce: Yes

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

Legal: No

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Welsh Language: No

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

Committee/Group/Exec	Date:

Report Title:	Procurement Compliance Report			Agenda Item no.	2.6
Meeting:	Audit Committee	Public	X	Meeting Date:	19 May 2026
		Private			
Status *(please tick one only)*:	Assurance	X	Approval		Information	
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Deputy Director of Procurement Services and Executive Procurement Lead – C&V				

Main Report

Background and current situation:

It is widely recognised and understood that the Health Board 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 Health Board'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 Health Board 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 (31)

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
MYRIAD GENETICS GMBH - Payment of Invoice 410004084	£21,780.00	Retrospective POI	AWMGS	No discussion with procurement prior to raising requisition.	Advised AWMGS that for any future requirements the end users liaise with Procurement Services in a timely manner to allow contract to be put into place via a compliant process.
Little Journey Application	£6,826.50	12 months	Surgery	No discussion with procurement prior to raising requisition.	Procurement not involved in process, added to workplan and advised including if

					renewal required for compliance.
PROJECT Genomic Switches - DALI Lighting issues-	£10,944.00	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. Urgent End of Year Spend	Agreed to process due to end of year urgency but end user reminded that over £5k orders need to be discussed with Procurement Services prior to raising.
Civility Saves Life Study Day – Payment of Invoice 202603021	£6,254.56	Retrospective POI	Children and Women	Retrospective payment of invoice – Procurement unaware of requirement prior to invoice being received.	Agreed to process as retrospective for services received. Emailed end user explaining over £5k orders need to be discussed with Procurement Services prior to raising.
Paediatric EU MDT Doc/Cascard Jan26 Qty 12000	£12,960.00	1 month	Medicine	Procurement picked this up as part of the over £5k validation check when requisition was submitted by the service. There had been no prior Procurement involvement.	This has now been picked up and included for ongoing purchases with Tender issued for longer term contract to be awarded.
WaveSense JAZZ Wireless Meters	£12,230.21	One-off Requirement	Medicine	Urgent end of year Bulk order, no procurement involvement.	Agreed to process due to end of year urgency but end user reminded that over £5k orders need to be discussed with Procurement Services prior to raising.
JAG Annual Subscription	£8,400.00	12 months	Medicine	Subscription fee but they require the PDF copy of the PO by 20th March no procurement involvement urgently required to continue service.	Added to procurement workplan to put appropriate governance compliance in place in time for renewal.
Call Off PO EZEC Transport	£90,000.00	3 months	Mental Health	This isn't a new breach. Procurement requested the requisition to be set up to allow invoices under No PO No Pay policy to be paid.	Contract Planning in process. Briefing paper is with WG.
Call Off PO Definitive PSA/Secure 24	£60,000.00	3 months	Mental Health	This isn't a new breach. Procurement requested the requisition to be set up to allow invoices under No PO No Pay policy to be paid.	Contract Planning in process. Briefing paper is with WG.
PO for Cardiff University	£37,999.20	One-off Requirement	Executives	No Procurement Involvement	No procurement involvement, can direct award under Horizontal Arrangements - Procurement Act 2023 but need to ensure governance is in place.
DZ-D100-AEACasio Dermoscopy cameras	£17,520.00	One-off Requirement	Medicine	Urgent end of year Bulk order, no procurement involvement.	Agreed to process due to end of year urgency but end user reminded that over £5k orders need to be discussed with Procurement Services prior to raising.
NOX Equipment	£17,278.56	One-off Requirement	Medicine	Urgent end of year Bulk order, no procurement involvement.	Agreed to process due to end of year urgency but end user reminded that over £5k orders need to be discussed with Procurement Services prior to raising.

Spirometer Equipment	£84,124.38	One-off Requirement	Medicine	Urgent end of year order, no procurement involvement	Agreed to process due to end of year urgency but end user reminded that over £5k orders need to be discussed with Procurement Services prior to raising.
PO to Pay Invoice - GenQA invoice no INV- 015048	£8,989.20	Retrospective POI	AWMGS	Retrospective payment of invoice – Procurement unaware of requirement prior to invoice being received.	Agreed to process as retrospective for services received. Emailed end user explaining over £5k orders need to be discussed with Procurement Services prior to raising.
The Knowledge Academy - Knowledge Pass Service - Qte Ref AWGS 26-26 KP	£29,994.00	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.	Explained to end user the process of orders over £5k and that they are to contact Procurement Services for any future orders that will be over the value of £5k.
Supply of a Lowara Ecocirc XL 65mm Twin Head Pump to replace obsolete unit.	£7,386.00	One-off Requirement	Capital Planning Estates and Facilities	Urgent requirement to replace obsolete unit	Explained to end user the process of orders over £5k and that they are to contact Procurement Services for any future requirements
Supply of Folders for clinical records	£28,222.80	3 months	Clinical Diagnostics &Therapies	No discussion with procurement prior to raising requisition.	Procurement Services in discussion with All Wales Team about putting in contract to capture ongoing requirements.
PO to Pay Invoice Only - Myriad Genetics Invoice 410004009	£13,200.00	Retrospective POI	AWMGS	No discussion with procurement prior to raising requisition.	Advised AWMGS that for any future requirements the end users liaise with Procurement Services in a timely manner to allow contract to be put into place via a compliant process.
Agency Staff	£6,614.40	Retrospective POI	Children & Women	No discussion with procurement prior to raising requisition.	Discussed SFI's for further procurement.
Clinical Service Training	£32,606.18	12 months	PCIC	No discussion with procurement prior to raising requisition.	Can be CCN on to a AW Contract but with no detail the timescales of 24hrs doesn't allow for completion.
Third Sector Facilitator Cardiff and Vale Hubs Programme with C3SC.	£25,000.00	Retrospective POI	Executives	RPB Funding. Thought this was managed by council with pass through finance but invoice received. Added to workplan for renewal.	Procurement have asked for next year to be sighted on these much earlier in the process so we can check compliance etc and VFM.
Perempo One year contract	£15,000.00	12 months	Medicine	Urgent End of Year Spend	Review usage and look to get contract in place with items available via catalogue.
200 Carbs and Cals App Codes and X18 World Food Books	£6,575.06	3.5-month secondment	Children & Women	No discussion with procurement prior to raising requisition.	Discussed SFI's for further procurement.
Pack of 25 Perpetual PITS including free P2 Energizer	£23,514.00	One off Requirement	Mental Health	No discussion with procurement prior to raising requisition.	Discussed SFI's for further procurement.
Payment of Invoice 2026/801	£7,008.00	1 month	Clinical Diagnostics &Therapies	No procurement Involvement, retrospective	Discussed with users that anything over £5k needs to come to procurement first.

One Wales MM Platform	£17,100.00	12-month retrospective	PCIC	No procurement involvement - retrospective	Contacted end user to understand contract and future requirements.
RCN Nurse of the Year 2026	£6,300.00	One off requirement	Executives	No procurement involvement - retrospective	Discussed with users that anything over £5k needs to come to procurement first. Looking at putting a contract in as this is an annual payment.
Haematology Reporting Outsourcing	£11,201.38	1 month	Clinical Diagnostics &Therapies	Delay in awarding contract whilst scoping of requirements and sign off completed	Contract documentation is in final sign off stage of governance.
701076674 BE-MECC 50312#Edinburgh NRP Pack	£9,922.50	1 month	Specialist	No procurement Involvement	Identified AW contract CLI-OJEU-46286(LOT2) to see if this item could be added and then added to catalogue.
Nursing and Midwifery conference	£15,743.00	One off requirement	Executives	No procurement Involvement	Not applicable- one off requirement.
Wales Gene Park Contribution to Rare Diseases Research Hub	£28,003.70	24 months	Children and Women	No procurement Involvement, retrospective project	Discussed with users that anything over £5k needs to come to procurement first. This value is expected to increase as the whole project has no compliance due to the department not coming to procurement for support.

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

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Storage of Document Boxes	£32,864.83	2025	One-off requirement	Executives	Miscommunication between stakeholders and supplier - documents were stored instead of incinerated	Invoice value breached contract value, after investigating agreed to release the hold to clear.
Service Contract XEVO TQ-S MICRO Serial Number 176600010	£34,334.52	13.06.25-12.06.26	12 months	Clinical Diagnostics & Therapies	Original Contract value approved did not include the value for this period.	Asset replaced with a 1-year warranty and added to workplan to pick up in 2027.

Other Non-Compliant Activity (3)

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
Emergency Work – HW N04 LTHW Steam Boiler Re-Tube	£33,600.00	One-off Requirement	Capital Planning Estates and Facilities	Emergency Activity	No Procurement involved. Have agreed to link in with procurement ahead of future works. Progressed on this occasion as emergency requirement.
Genedrive MT-RNR1 ID KIT	£10,560.00	1 month	Children and Women	Emergency Activity	The All-Wales team are currently putting the contract

					in place and going through sign off
Sunchip 2 Open Set	£16,008.00	1 month	Children and Women	Urgently required not enough time to put procurement governance in place	Reviewing the spending to put the governance in place for future orders

Exemptions (2) (Permitted within SFI's)

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Rent and Rates across various locations for this period	£8,727,434.37	12 months	Health Board Wide	Exemption	This expenditure is exempt under Rent and Rates
Legal Services across various locations for this period	£80,503.65	One off requirement	Executives	Exemptions	This expenditure is exempt under Legal Services

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

Report on Single Tender/Quotations Actions

Retrospective – (Nil Return)

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (7) requests during the period from the 1st February 2026 to 31st April 2026.

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

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
Surgery	Minim Healthcare	Bulk of Neuro Consumables	£86,893.44	Sole Supplier of Goods or Services
Clinical Diagnostics & Therapies	Smartsheets	Smartsheet provision for AWTTC	£9,000.68	Sole Supplier of Goods or Services
Clinical Diagnostics & Therapies	Royal College of Physicians	Pharmacy Training	£6,142.70	Sole Supplier of Goods or Services
Clinical Diagnostics & Therapies	Blue-Teq	BlueTeq DHCW	£39,900.00	Sole Supplier of Goods or Services
Clinical Diagnostics & Therapies	Swansea University	Gabapentinoid project	£10,260.00	Sole Supplier of Goods or Services
Clinical Diagnostics & Therapies	Bangor University	Health Economist Support for AWTTC	£107,221.87	Sole Supplier of Goods or Services
Clinical Diagnostics & Therapies	Sprezzatura	UKHSA Agreement for Toxicology	£62,371.32	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

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

	2023/24 (FY)		2024/25 (FY)		2025/26(YTD)	
Clinical Board	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption
AWMGS	1	0	14	0	15	2
Children and Women	3	0	11	0	11	3
Capital Planning, Estates and Facilities	2	3	17	7	21	29
Clinical, Diagnostics and Therapies	11	4	27	4	31	18
Executives	21	9	35	20	13	7
Medicine	1	0	3	0	9	0
Mental Health	2	1	10	0	4	4
PCIC	2	0	11	0	9	6
Specialist	10	1	11	2	11	2
Surgery and Dental	10	0	8	1	5	0
TOTALS	**63**	**18**	**147**	**34**	**133**	**70**

STA/SQA's by Department

	2023/24 (FY)		2024/25 (FY)		2025/26(YTD)	
Clinical Board	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached
AWMGS	0	0	6	1	1	0
Children and Women	4	0	2	0	2	0
Capital Planning, Estates and Facilities	2	0	7	0	2	0
Clinical, Diagnostics and Therapies inc. Weqas	23	0	34	0	12	0
Executives	13	2	22	2	2	0
Medicine	0	0	3	0	1	0
Mental Health	1	0	3	0	0	0
PCIC	3	0	4	0	0	0
Specialist Services	3	0	5	2	0	0
Surgery Services and Dental	5	1	9	0	1	0
Grand Total	**54**	**3**	**95**	**5**	**21**	**0**

Summary of the Key Issues progress

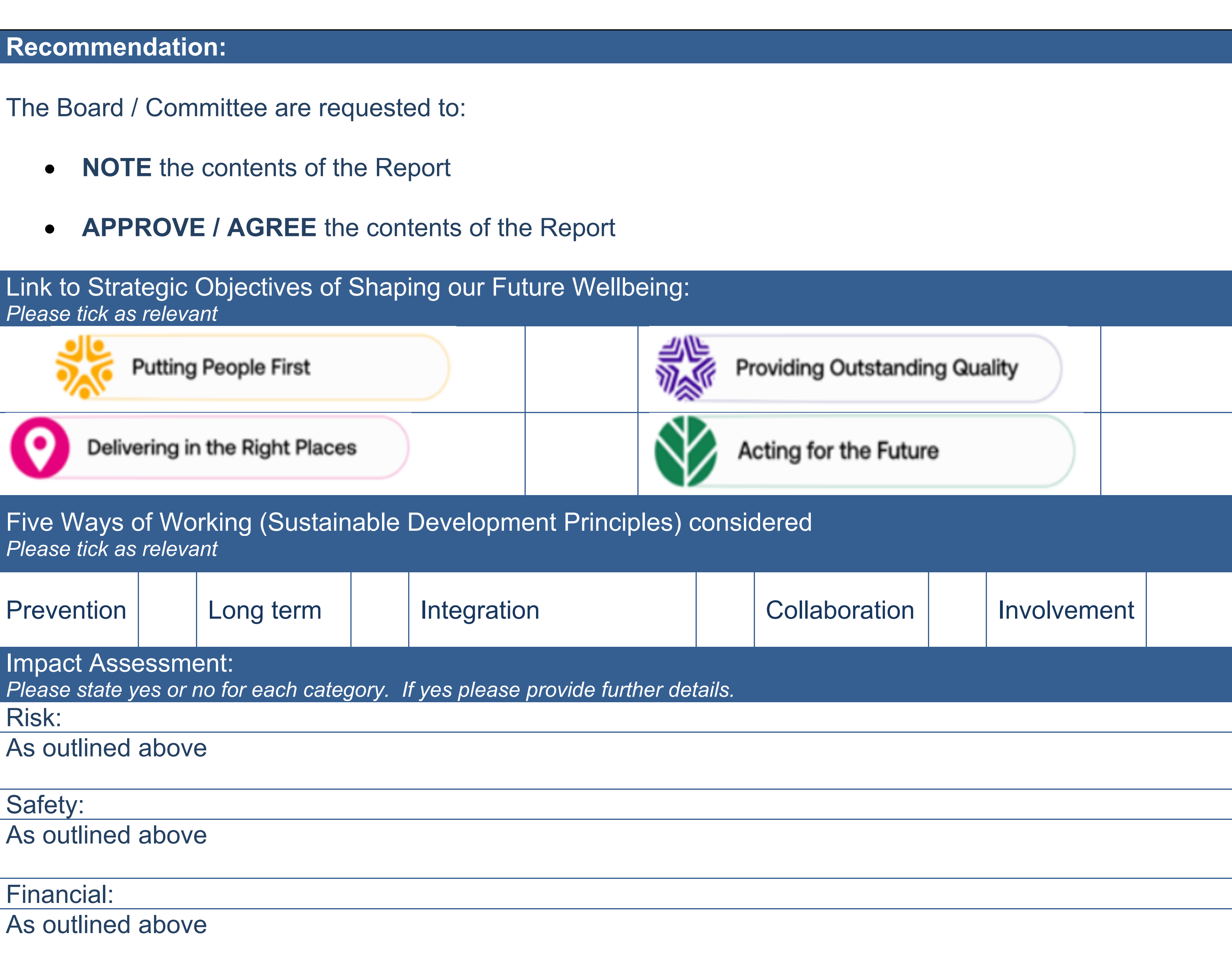
Work continues to address the key drivers of non-compliance across Clinical Boards. Procurement has observed ongoing fluctuations in non-compliant spend, largely linked to exemptions, emergency repairs, and retrospective approvals. Awareness of Standing Financial Instructions (SFI's) remains varied across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

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

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

The Procurement team have developed an online e-learning module on procurement that can be shared with Clinical Boards as part of the procurement training and ongoing education/understanding of what is required and when – this is currently in testing stages and will be rolled out to all Clinical Boards with the aim of reducing the non-compliant spend activity.

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



Recommendation:

The 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

Prevention		Long term		Integration		Collaboration		Involvement	

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:

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

Category reason for SQA/STA's

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

Retrospective – (Nil Return)

The report outlines all retrospective SQA/STA (0) requests during the period the 1st February 2026 to 31st April 2026.

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

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (6) requests during the period the 1st February 2026 to 31st April 2026.

The volume processed was because of the following: -

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

Clinical Board	**Proposed Supplier**	**Name of Project**	**Total Value of Contract Excl VAT**	**Type**	**Reason Detail for STA**	**Category**
Surgery	Minim Healthcare	Bulk of Neuro Consumables	£86,893.44	Sole Supplier of Goods or Services	No other solution currently, Neurosurgical equipment only compatible with specific products – Year End Spend	2
Clinical Diagnostics & Therapies	Smartsheets	Smartsheet provision for AWTTC	£9,000.68	Standardisation of goods or services	AWTTC who classifies as a ring-fenced spend has been using Smartsheets since 2018, where all their system data is stored on and in use since.	10
Clinical Diagnostics & Therapies	Royal College of Physicians	Pharmacy Training	£6,142.70	Sole Supplier of Goods or Services	No other solution currently	10
Clinical Diagnostics & Therapies	Blue-Teq	BlueTeq DHCW	£39,900.00	Sole Supplier of Goods or Services	No other solution currently	10

Clinical Diagnostics & Therapies	Swansea University	Gabapentinoid project	£10,260.00	Partnership Arrangements	No other solution currently	7
Clinical Diagnostics & Therapies	Bangor University	Health Economist Support for AWTTC	£107,221.87	Partnership Arrangements	The economist is as a value where the HB could not procure for this value	7
Clinical Diagnostics & Therapies	Sprezzatura	UKHSA Agreement for Toxicology	£62,371.32	Sole Supplier of Goods or Services	The bespoke software used by all UK National Poisons Information Services was developed and is maintained by Sprezzatura.	5

STA/ SQA	SQA/STA Number	Contract Folder Number	Procurement Officer	Date Received	Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Annual Value of Contract excl VAT	Retrospective?	Retrospective Value of Contract excl VAT	Start Date of Contract	End Date of Contract	Extension Option	Type	Category of STA/SQA for Audit Paper	Reason Detail for STA	Long Term Solution
STA	(2025/26) 79	SS1 SAV	SAS	17/03/2026	Surgery	Minim Healthcare	Bulk of Neuro Consumables	£72,411.20	£86,893.44	No	N/A	One off	One off	None	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Sole Supplier of Goods or Services	No other solution currently, Neurosurgical equipment only compatiable with specific products
SQA	(2025/26) 71	QU401	CW	02/02/2026	CD&T	Samrtsheets	Smaertsheet provision for AWTTC	£9,000.68	No	No	N/A	One off requirement	08/02/2027	None	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Sole Supplier of Goods or Services	AWTTC who classifies as a ring-fenced spend has been using Smartsheets since 2018, where all of their system data is stored on and in use since.
SQA	(2025/26) 72	QU776 -	JS	13/02/2026	CD&T	Royal College of Physicians	Pharmacy Training	£6,142.70	£6,142.70	No	N/A	One off requirement	One off requirement	None	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Sole Supplier of Goods or Services	No other solution currently
STA	(2025/26) 73	CR1514	CW	27/02/2026	CD&T	blue teq	BlueTeq DHCW	£33,250.00	£39,900.00	No	N/A	One off requirement	One off requirement	None	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Sole Supplier of Goods or Services	No other solution currently
SQA	(2025/26) 74	QU774	CW	27/02/2026	CD&T	swansea univrsity	Gabapentinoid project	£8,550.00	£10,260.00	No	N/A	One off requirement	One off requirement	None	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Sole Supplier of Goods or Services	No other solution currently
STA	(2026/27) 2	CR155	CW	22/04/2026	AWTTC	Bangor University	Health Economist Support for AWTTC	£89,351.56	£107,221.87	No	N/A	01/05/2026	£47,238.00	N/A	Sole Supplier of Goods or Services	Sole Supplier of Goods or Services	The enconomist is as a value where the HB could not procure for this value	Possibly look to bring a health economist in although via university is more cost effective
STA	(2026/27) 3	CR1548	CW	29/04/2026	Toxicology	Sprezzatura	UKHSA Agreement for Toxicology	£51,976.10	£62,371.32	No	N/A	01/05/2026	£46,507.00	N/A	Sole Supplier of Goods or Services	Sole Supplier of Goods or Services	The bespoke software used by all UK National Poisons Information Services was developed and is maintained by Sprezzatura.	

Report Title:	Draft Audit Committee Annual Report 2025/26			Agenda Item No:	3.1
Meeting:	Audit & Assurance Committee	Public	x	Meeting Date:	19.05.2026
		Private			
Status:	Assurance		Approval x	Information/Noting	
Lead Executive Title:	Director of Corporate Governance				
Report Author Title:	Senior Corporate Governance Officer				

Main Report

Background and Current Situation:

An Annual Report from the Committee is produced to demonstrate that it has undertaken the duties set out in its Terms of Reference and to provide assurance to the Board that this is the case.

The purpose of the Annual Report is to provide Members of the Audit Committee with the opportunity to discuss the attached draft annual report before being submitted to the Board for approval on 28 May 2026.

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

The Committee achieved an overall attendance rate of 77% from the period 1 April 2025 to 31 March 2026 and met on five occasions during the year.

The attached Annual Report 2025/26 of the Audit Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

a) Audit & Assurance Committee Annual Report

Recommendations:

a) **NOTE** the contents of the report
b) **ENDORSE** the report to the Board for approval

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First		2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. Acting for the Future	x

Five Waves of Working (Sustainable Development Principles) considered:

Please place an "x" in the below boxes where relevant

Prevention		Long Term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?

Please place an "x" in the below boxes where relevant

Yes	x	No	x	N/A

Impact Assessment Please place an “x” in the below boxes where relevant
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: Yes
As per 10.2.2 of the Health Board Standing Orders: *“Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established”.*
Reputational: No
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route ***(please list all other Committees/Groups this report has been to)***	
Name of Committee/Group/Exec	Date:

Annual Report of the Audit & Assurance Committee 2025/26

1. INTRODUCTION

In accordance with best practice and principles of good governance, the Audit & Assurance Committee produces an Annual Report to the Board setting out how the Committee has discharged its responsibilities and met its Terms of Reference during the financial year 2025/26. The report provides an overview of the work undertaken, key areas of focus, and the assurance provided to the Board and the Accountable Officer.

2. MEETINGS OF THE COMMITTEE

The Audit & Assurance Committee met five times during the 2025/26 financial year, including one special meeting convened to review and endorse the Annual Report and Accounts. Meetings were held in public with additional private sessions where required to consider confidential matters:

Attendance	20.05.25	25.06.25	02.09.25	18.11.25	13.01.26	Percentage
Rhian Thomas	☑	☑	☑	☑	☑	100.00%
David Edwards	☑	☑	☑	☑	☑	100.00%
Mike Jones	☑	☑	☑			100.00%
John Union	☐	☑	☐			33.33%
Ceri Phillips	☑	☑	☑	☑	☑	100.00%
Rachna Upadhya	☐	☑	☐	☑	☐	40.00%
Catherine Phillips	☐	☑	☐	☑	☑	60.00%
Rachel Gidman	☑	☑	☐	☐	☑	60.00%
Matt Phillips	☑	☑	☑	☑	☑	100.00%

3. TERMS OF REFERENCE

The Committee operated in accordance with its Terms of Reference, which define its role in providing independent assurance to the Board on the effectiveness of governance, risk management, and internal control arrangements. The Committee's remit includes oversight of internal and external audit, counter fraud arrangements, financial reporting, regulatory compliance, and procurement governance.

4. WORK UNDERTAKEN DURING THE YEAR

During 2025/26 the Committee undertook a substantial programme of work aligned to its Terms of Reference. This section summarises the key areas of business considered throughout the year.

4.1 Internal Audit

Internal Audit progress and output reports were presented at each scheduled Committee meeting, providing assurance on the delivery of the Internal Audit Plan and the effectiveness of internal controls across the organisation.

The Committee considered a wide range of internal audit reviews covering clinical governance, financial management, digital and information governance, workforce, estates, procurement, risk

management, and strategic planning. Assurance ratings ranged from substantial to limited, with advisory reviews also undertaken in complex or evolving areas.

Where audits resulted in limited assurance, responsible Executives attended meetings to provide additional context, agree actions, and outline improvement plans. The Committee maintained particular oversight of audits relating to cyber security, procurement compliance, quality and safety governance, workforce planning, and major programmes.

4.2 Head of Internal Audit Opinion

The Committee reviewed and endorsed the Head of Internal Audit Opinion and Annual Report, which provided an overall assessment of the adequacy and effectiveness of the organisation's governance, risk management, and internal control framework. The opinion informed the Annual Governance Statement within the Health Board's Annual Report.

4.3 External Audit – Audit Wales

At each meeting the Committee received comprehensive updates from Audit Wales on financial audit, performance audit, and national studies relevant to the Health Board. These updates included progress on the audit of the annual accounts, charitable funds audit, structured assessment work, and thematic reviews such as planned care and eye care services.

The Committee reviewed significant Audit Wales reports, including those relating to planned care recovery, eye care services, structured assessment findings, and the Annual Audit Summary. Management responses were scrutinised, and assurance sought on how recommendations would be implemented and tracked.

4.4 Financial Reporting and Annual Accounts

The Committee played a key role in the scrutiny and oversight of the Health Board's Annual Report and Accounts. It reviewed the draft Annual Report, Accountability Report, Performance Report, and Financial Statements prior to submission to Audit Wales.

Following external audit, the Committee considered the ISA 260 Report, Letter of Representation, and management responses to audit enquiries. It recommended approval of the Annual Report and Accounts to the Board and endorsed them for submission to Welsh Government and the Senedd.

4.5 Risk Management and Assurance Framework

The Committee monitored the development and implementation of the organisation's risk management framework, including the transition to the Audit Management and Tracking (AMAT) system. It reviewed the Risk Management Policy, received updates on the Board Assurance Framework, and sought assurance on the identification, escalation, and management of risks across the organisation.

4.6 Procurement and Financial Governance

Procurement Compliance Reports were received at each meeting, providing transparency on non-compliant activity, Single Tender Actions, exemptions, and Chairs' Actions. The Committee

scrutinised trends and required enhanced narrative and data to understand underlying causes and mitigations.

Deep dives into procurement and non-pay spend were undertaken to explore controls, value for money, and emerging risks. The Committee noted improvements in compliance over the year and requested continued focus on education, early engagement, and assurance on delegated authority arrangements.

4.7 Counter Fraud

The Committee received regular Counter Fraud Progress Updates and reviewed the Counter Fraud Annual Report and Counter Fraud Plan. Assurance was taken that counter fraud arrangements met national standards and that investigative, preventative, and awareness-raising activity was effective.

4.8 Recommendation and Action Tracking

Throughout the year the Committee maintained oversight of internal audit, external audit, and regulatory recommendations through the use of centralised tracking via the AMAT system. Updates demonstrated improving completion rates, reduced numbers of long-outstanding actions, and strengthening executive ownership.

4.9 Committee Approvals

During the course of the 2025–26 financial year, the Audit & Assurance Committee approved the following key items:

- Internal Audit Plan 2025/26, including the Internal Audit Mandate, Charter, resource requirements, and key performance indicators
- Adjustments to the Internal Audit Plan during the year to reflect emerging risks, delivery challenges, and Committee priorities
- Head of Internal Audit Opinion and Annual Report 2024/25, confirming the level of assurance that could be taken over governance, risk management, and internal control
- Annual Report and Accounts 2024/25, including:
  - ISA 260 Report (Communication with Those Charged with Governance)
  - Letter of Representation
  - Responses to Audit Enquiries for onward recommendation to the Board
- Audit & Assurance Committee Annual Report 2024/25 for submission to the Board
- Risk Management Policy, reflecting the transition to the Audit Management and Tracking (AMAT) system and revised organisational risk arrangements.
- Counter Fraud Annual Report 2024/25, confirming compliance with national counter fraud standards and effectiveness of arrangements.
- Counter Fraud Plan 2025-26
- Losses and Special Payments recommended by the Losses and Special Payments Panel for the relevant reporting period
- Procurement Compliance Reports, including approval/agreement of reported activity, mitigations, and improvements to reporting and controls during the year

4.10 Private Session Business

In line with standard practice, the Committee held private sessions to consider confidential matters, including counter fraud investigations, people and culture assurance, and sensitive audit findings. These sessions provided additional assurance and enabled open discussion where appropriate.

5. REPORTING TO THE BOARD

Following each meeting, the Committee reported key issues, assurances, and matters of significance to the Board through summary reports and formal minutes. Urgent or emerging issues were escalated as required to ensure appropriate awareness and action.

6. CONCLUSION AND OPINION

The Audit & Assurance Committee is satisfied that during 2025/26 it discharged its responsibilities in accordance with its Terms of Reference and provided the Board with effective independent assurance on governance, risk management, and internal control arrangements. The Committee is not aware of any matters that should be brought to the Board's attention that have not been appropriately disclosed during the year.

David Edwards

Committee Chair

Report Title:	Losses and Special Payments Panel Report 2025-2026			Agenda Item no.	3.2
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	19th May 2026
		Private			
Status *(please tick one only)*:	Assurance	Approval	X	Information	
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Assistant Director of Finance				

Main Report
Background and current situation:

As defined in the Standing Financial Instructions, the Audit and Assurance Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit and Assurance Committee with this task, the UHB has established a Losses and Special Payments Panel, under the chairmanship of the Executive Director of Finance (delegated to the Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.

The work of the panel supports the UHB's sustainability and ensures that we make the best use of the resources that we have.

This report informs the Audit and Assurance Committee of the items considered at the Losses & Special Payments Panel meetings held on 11th November 2025 and 12th May 2026.

The Losses and Special Payments Panel met on 11th November 2025 to consider the period 1st April 2025 to 30th September 2025 in respect of;

- Clinical Negligence & Personal Injury
- Bad Debt write-off's
- Ex-gratia and other losses
- Small Claims
- Employment Tribunals
- Counter Fraud

The minutes of the Panel meeting are attached as **Appendix 1 (located in the supporting documents folder).** The minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the Audit & Assurance Committee for approval.

The next Losses & Special Payments Panel met on 12th May 2026 to consider the period 1st October 2025 to 31st March 2026 in respect of;

- Clinical Negligence & Personal Injury
- Bad Debt write-off's
- Ex-gratia and other losses
- Small Claims
- Employment Tribunals
- Counter Fraud

The Losses & Special Payments Panel also considered the longer period of 1st April 2025 to 31st March 2026 in respect of;

- Permanent Injury
- Stock write-off's
- Voluntary Early Release

The minutes of the Panel meeting are attached as **Appendix 2 (also located in the supporting documents folder)**. The minutes give more detail about the issues discussed at the meeting, including those items that have been recommended to the Audit & Assurance Committee for approval.

This will complete the approval of all Losses & Special Payments to be written off in the year 2025-2026 that are included within the draft Cardiff & Vale UHB Annual Accounts submission.

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

The losses and special payments discussed at the Losses & Special Payments Panels require consideration and approval by the Audit and Assurance Committee.

The following losses have been identified for write off:

- **Clinical Negligence claims of £26.591m for the full year 2025-2026** (£20.666m for the period 1st April 2025 to 30th September 2025, £5.925m for the period 1st October 2025 to 31st March 2026). **Personal Injury claims of £0.132 for the full year 2025-2026** (£0.054m for the period 1st April 2025 to 30th September 2026, £0.078m for the period 1st October 2025 to 31st March 2026)

- **Bad Debt write-offs of £565,319 for the full year 2025-2026** (£43,185 for the period 1st April 2025 to 30th September 2025, £522,134 for the period 1st October 2025 to 31st March 2026)

- **Ex gratia and other losses of £123,594 for the full year 2025-2026** (£27,289 for the period 1st April 2025 to 30th September 2025, £96,305 for the period 1st October 2025 to 31st March 2026)

- **Small Claims losses of £40,935 for the full year 2025-2026** (£17,851 for the period 1st April 2025 to 30th September 2025, £23,084 for the period 1st October 2025 to 31st March 2026)

- **Employment Tribunal losses of £67,390 for the full year 2025-2026** (£20,000 for the period 1st April 2025 to 30th September 2025, £47,390 for the period 1st October 2025 to 31st March 2026)

- **Stock losses of £642,648 for the full year 2025-2026**

- **Voluntary Early Release payments of £480,756 for the full year 2025-2026.**

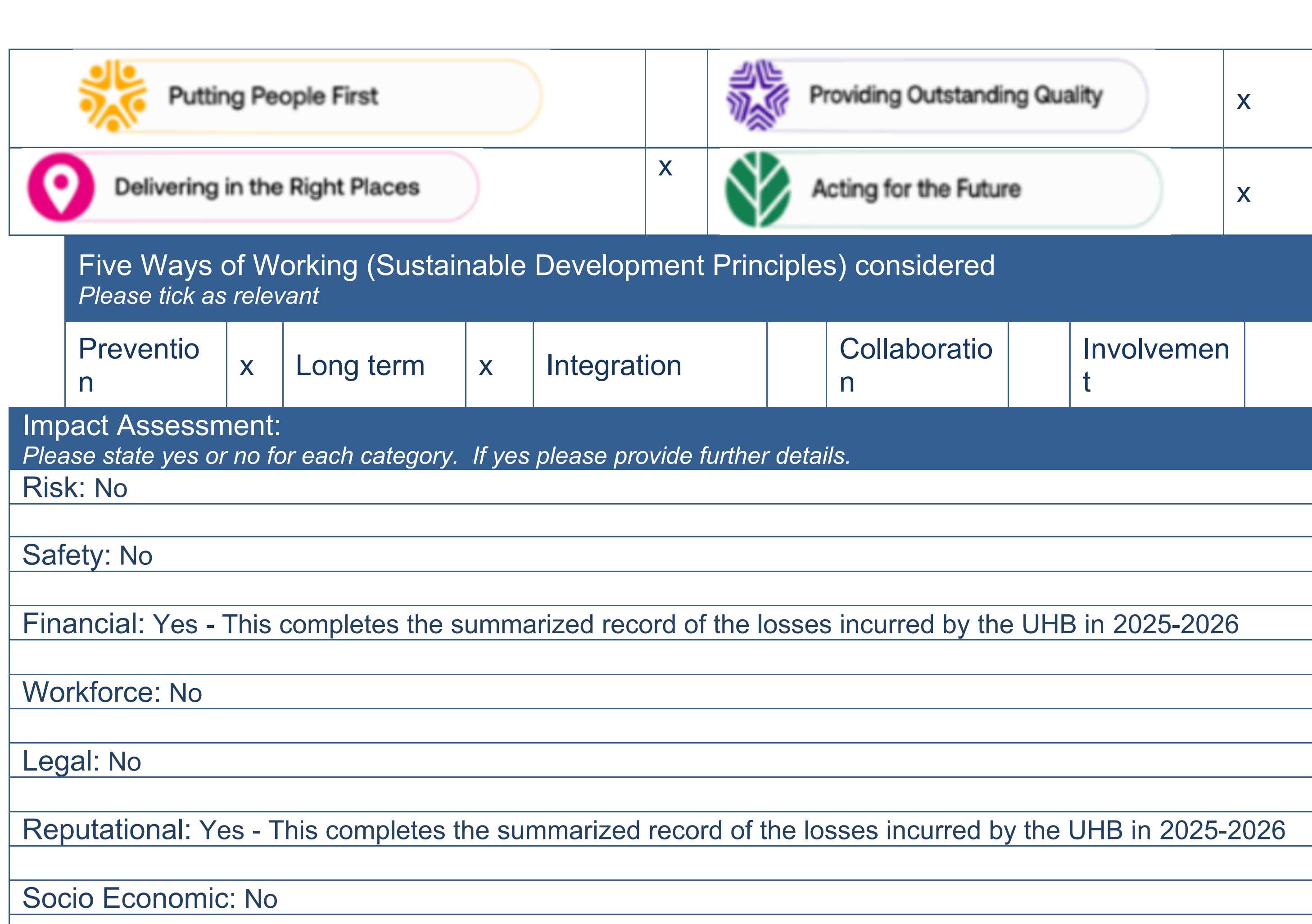
Recommendation:

The Committee are requested to:

- **APPROVE** the write offs for the period outlined in the Opinion and Key Issues Section of this report as recommended by the Losses and Special Payments Panels held on **11th November 2025** and **12th May 2026.**

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		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: Yes - This completes the summarized record of the losses incurred by the UHB in 2025-2026
Workforce: No
Legal: No
Reputational: Yes - This completes the summarized record of the losses incurred by the UHB in 2025-2026
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

<table>
<tr><td>Report Title:</td><td colspan="4">Declarations of Interest Report</td><td colspan="2">Agenda Item no.</td><td colspan="2">4.1</td></tr>
<tr><td rowspan="2">Meeting:</td><td colspan="2" rowspan="2">Audit and Assurance Committee</td><td>Public</td><td>x</td><td rowspan="2">Meeting Date:</td><td colspan="3" rowspan="2">19th May 2026</td></tr>
<tr><td>Private</td><td></td></tr>
<tr><td>Status:</td><td>Assurance</td><td>x</td><td>Approval</td><td></td><td colspan="2">Information</td><td></td></tr>
<tr><td>Lead Executive:</td><td colspan="8">Director of Corporate Governance</td></tr>
<tr><td>Report Author:</td><td colspan="8">Corporate Archivist and Records Management Manager</td></tr>
</table>

Background and current situation:

This paper is designed to set out the current position and provide the Committee with an update and assurance regarding the portfolio covering Declarations (conflicts) of Interest, Outside Employment, Gifts, Hospitality, and Sponsorship.

Declarations of Interest Process

The process remains unaltered, and Employees are required to make a single declaration of interest during their period of employment, only altering it if their circumstances change (for example undertaking secondary employment).

All Declarations of interest should be made via the ESR platform.

The Corporate Governance Team have worked with Corporate Communications to design and implement a Communication Plan that informs staff members of the following:

- The requirement to now submit a declaration of interest once on joining the organisation. But, reinforcing the requirement to update if personal circumstances change.
- That Declarations of Interest should now only be made on ESR, and signposting to User and Manager guides.
- The continuing need to declare Outside Employment, Gifts, Hospitality and Sponsorship with specific emphasis being given in Autumn (for Autumn International Rugby Tickets) and Christmas/New Year (for seasonal gifts).

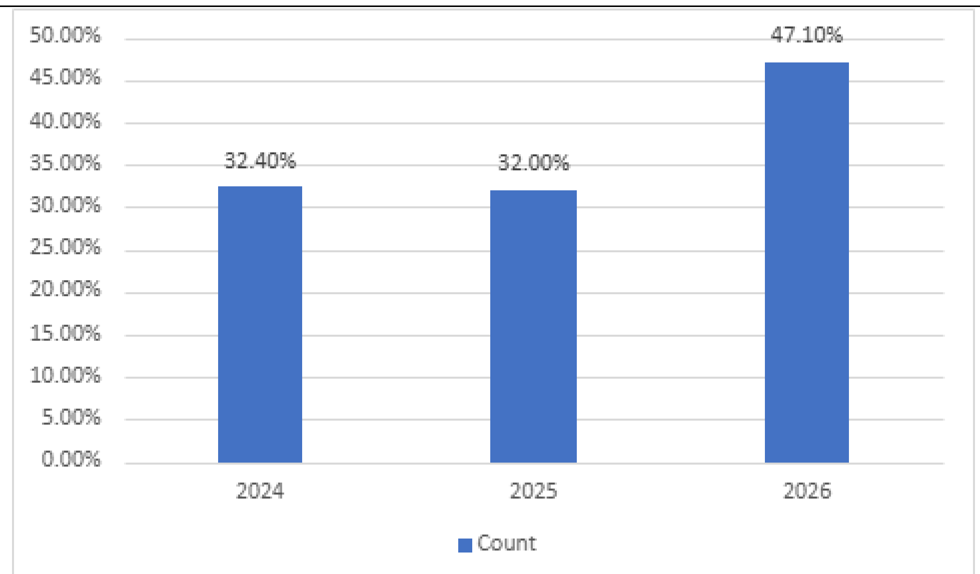
Board Member Declarations

In addition to the requirements outlined above, it is mandatory for Board Members to submit an annual declaration at the end of each financial year for audit purposes. At the conclusion of the 24/25 financial year, a collaborative effort was undertaken to facilitate the transition to the ESR platform for the submission of these declarations. This transition proved to be highly successful, resulting in the full digitisation of the process for subsequent years and the elimination of individual paper records. The adoption of the ESR method has not only streamlined the submission process but has also enhanced the efficiency and accessibility of annual declarations for Board Members.

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

Present position of Declarations

CVUHB has taken a pragmatic approach to declarations and has determined that employees at Bands 7 and above – and equivalent non-agenda for change roles – are likely to be key organisational decision-makers. As such, DOI tracking and data is focused on them



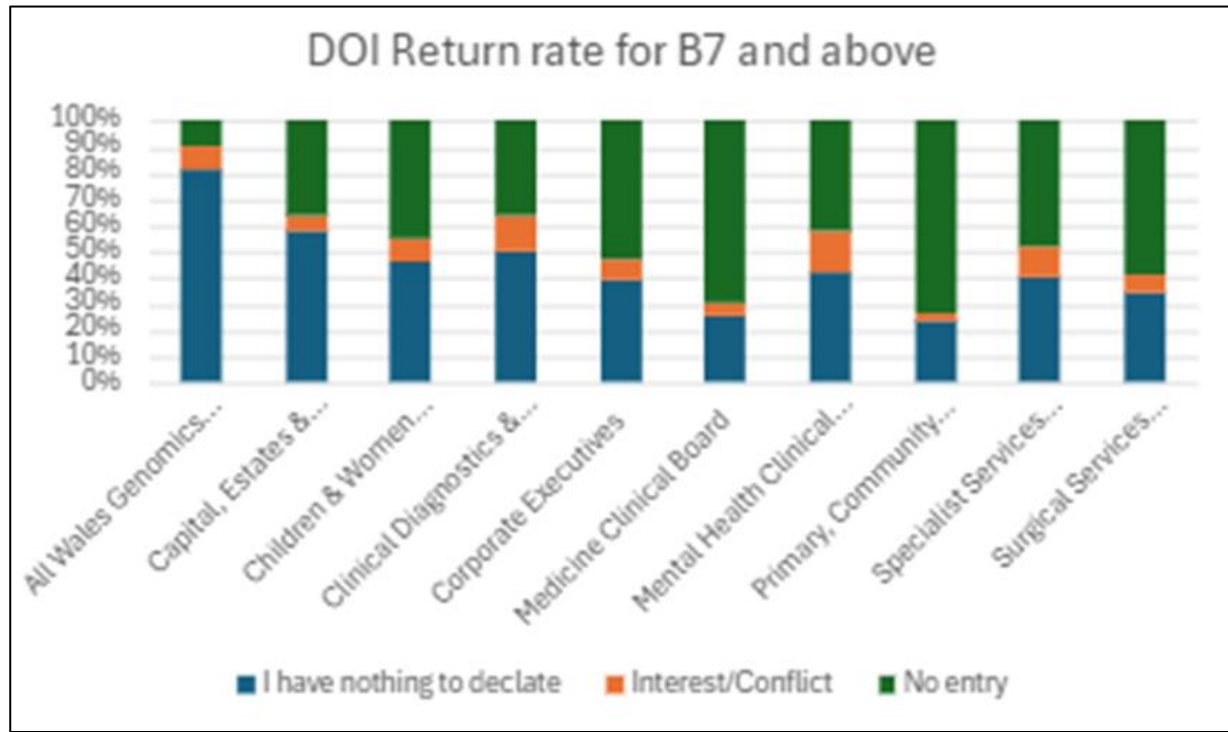
Graph 1. Year on Year entries of Band 7and above via ESR

These declaration completion rates are tracked throughout the year and regularly reported in Clinical Board reviews with individual follow up with each CB

To boost submission rates, a focused direct mail campaign was launched in December 2025. This initiative effectively increased the overall organisational return rate; this saw declarations increase by 2482 and will be repeated again later this year

Corporate Governance provides regular updates containing statistics and figures for each service area. Data specific to each clinical board will be developed and submitted quarterly throughout 2026-2027. Line managers and clinical boards are responsible for reviewing their own submissions within the system.

This process enables continued transparency and supports departmental accountability regarding any potential conflicts and the declarations of interest, outside employment, gifts, hospitality, and sponsorship.



Graph 2. Overview of each clinical board

Historically, the RAG (Red, Amber, Green) rating of Declarations of Interests forms was not mandated by formal policy. Instead, it was adopted as an interim measure by the Corporate Governance team to provide oversight of paper-based submissions that otherwise lacked systematic review. This manual RAG rating

process functioned as a notification mechanism, alerting line managers and clinical boards to high-risk declarations and prompting appropriate follow-up or investigation as necessary.

With the implementation of the fully automated ESR system, line managers now have direct and comprehensive oversight of their staff's declarations. This access is comparable to their visibility over mandatory training, appraisals, and annual leave records. The integration of declaration monitoring within the ESR platform has streamlined the process, ensuring that the oversight and management of declarations are efficiently conducted at the local level.

A register of all declared interests can be found at the following, public-facing, link (which will need to be copied and pasted into a web browser to access):

Declarations of Interest table May 2026

Improvements have been carried out on the Corporate Governance SharePoint which now includes a dedicated page to ESR Guidance for the process of declaring a conflict/interest.

It is noted that Audit Committee will be provided with an update on the Declarations of Interest portfolio annually, with the next update scheduled to be shared at Audit Committee in Quarter 1 of 2027-2028. Reports will of course be provided by exception for the remainder of the year if there is a requirement to escalate such matters to Committee.

There is a duty of transparency and openness that means the recording of DOIs and publication of the register is a relevant output in itself, but having a register and growing knowledge of DOIs in the organisation manifests other activity. Procurement processes as a matter of course require participants to complete a DOI statement to ensure probity in contract awarding and wherever there are local questions by line managers they contact the Director of Corporate Governance or the Corporate Governance team directly to seek clarification on matters. It is a dynamic system in use and not a static, data collection exercise.

Recommendation:

The Committee are requested to:

a) **Note** the contents of the Report.

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

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

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

Yes		No		

Impact Assessment:
Risk: Yes
There is a risk that non-declaration of an interest by staff members could result in breaches of legal and/or regulatory requirements, specifically in a procurement context. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
Should staff members fail to comply with the Health Board's Standards of Behaviour Policy and examples of this are made public, there is a possibility that this could have an adverse reputational impact on the Health Board and its staff body. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

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

Report Title:	Counter Fraud Progress Report				Agenda Item no.	4.2.1
Meeting:	Audit & Assurance Committee		Public	x	Meeting Date:	19/05/2026
			Private			
Status *(please tick one only)*:	Assurance	x	Approval		Information	x
Lead Executive:	Catherine Phillips					
Report Author (Title):	Henry Bales					

Main Report
Background and current situation:

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

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

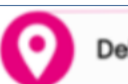
Executive Director Opinion and Key Issues to bring to the attention of the Committee:

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

Recommendation:

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

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

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

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

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

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

Risk: Yes/~~No~~

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

Safety: ~~Yes~~/No

Financial: Yes/~~No~~

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

Workforce: Yes/~~No~~

Reduction of available staff during investigations and sanctions; demotivation

Legal: Yes/No

Reputational: Yes/~~No~~

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

Socio Economic: ~~Yes~~/No

Equality and Health: ~~Yes~~/No

Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Catherine Phillips	

NHS WALES

Counter Fraud Progress Report

17/01/2026 – 28/04/2026

Public

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 17/01/2026 – 28/04/2026.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2025-2026 and 2026-2027, and the NHS CFA functional standards. The below activity has taken place -

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

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

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

E-Learning Awareness Sessions – The ESR E-Learning package remains available for staff to access and is promoted through the Counter Fraud SharePoint page and our other publications. Proposal to request mandating of this e-learning has been submitted to the Education, Culture and Organisational Development team.

Awareness Sessions – Counter Fraud continue to participate in corporate induction events for new starters. During this period two of these sessions has taken place with 'mini' talks being given to all in attendance (circa 80 members of staff).

Newsletter – A counter fraud newsletter was created, circulated and publicised in February. You can view the newsletter by following this link February 2026 - Counter Fraud Newsletter (you will need to log in to your NHS Microsoft account to view).

Prevention

IBURN/Alerts (intelligence bulletins) – (5)

1. Report of a potential compromised third-party business email address was received. No issues identified however alert created and circulated to relevant individuals.
2. Intelligence relating to a missing prescription pad outside of health board area. Alert circulated to relevant individuals.
3. Intelligence regarding potential patient fraud at A&E's in Wales, alert circulated with relevant information to A&E department.
4. Intelligence relating to a missing prescription pad outside of health board area. Alert circulated to relevant individuals.
5. Intelligence regarding payment provider transaction scams, no issues identified for CAVUHB, alert circulated.

System Weakness Report (SWR) – (1)

System weakness report regarding on-call arrangements in digital directorate created and shared with directorate though AMAT. Recommendations and any actions will be tracked through AMAT.

National Fraud Initiative

The NFI exercise has been completed for this cycle, no issues have been identified for HEIW.

Work is being undertaken with Audit Wales and the NFI system provider to look for further uses of NFI for the organisation including their "AppCheck" system.

Referrals

During this reporting period there have been a total of 33 referrals made to the team. 9 of these referrals have been promoted to investigations (detailed in next section). 4 referrals remain in initial assessment stage. The remaining referrals have all been closed.

Investigations

During this period there have been 10 investigations commenced by the counter fraud team. There have been 9 investigations that have been closed on the system. This means that there are currently 10 investigations open at the time of this report. Summaries of the opened, closed and currently open cases are shown below.

Investigations opened in the period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/26/00389	Timesheet False Claim	CARRIED OVER - 05/02/2026	25/03/2026	No fraud found
INV/26/00529	Primary Care False Claims	CARRIED OVER - 16/02/2026	17/02/2026	No fraud found
INV/26/00801	Theft of Prescription Pad	CARRIED OVER - 05/03/2026	31/03/2026	No offender identified
INV/26/00802	Individual selling drugs and prescription medication	CARRIED OVER - 05/03/2026	17/03/2026	Matter referred to Police.
INV/26/00807	Individual selling prescription medication	CARRIED OVER - 05/03/2026	17/03/2026	Matter referred to Police.
INV/26/00890	Working elsewhere whilst sick	CARRIED OVER - 11/03/2026		
INV/26/00979	Accessing records	CARRIED OVER - 23/03/2026		
INV/26/01166	Overseas Patient	CARRIED OVER - 31/03/2026		
INV/26/01338	Theft of medication and record book	20/04/2026	28/04/2026	No offender identified - LPE/SWR work ongoing
INV/26/01340	Primary Care Prescribing irregularities	21/04/2026		

Investigations Closed in this period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/25/00720	Theft of Cash and Medication	CARRIED OVER - 11/03/2025	28/04/2026	Final written warning
INV/25/03947	Access to data	CARRIED OVER - 23/12/2025	27/01/2026	No fraud found
INV/25/03953	Theft of Cash	CARRIED OVER - 23/12/2025	23/01/2026	Unable to identify suspect
INV/26/00389	Timesheet False Claim	CARRIED OVER - 05/02/2026	25/03/2026	No fraud found
INV/26/00529	Primary Care False Claims	CARRIED OVER - 16/02/2026	17/02/2026	No fraud found
INV/26/00801	Theft of Prescription Pad	CARRIED OVER - 05/03/2026	31/03/2026	No offender identified
INV/26/00802	Individual selling drugs and prescription medication	CARRIED OVER - 05/03/2026	17/03/2026	Matter referred to Police.
INV/26/00807	Individual selling prescription medication	CARRIED OVER - 05/03/2026	17/03/2026	Matter referred to Police.
INV/26/01338	Theft of medication and record book	20/04/2026	28/04/2026	No offender identified - LPE/SWR work ongoing

Investigations that remain open

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/01634	Salary Sacrifice Vehicle	CARRIED OVER - 03/08/2023		
INV/23/02002	Theft of Controlled Drugs	CARRIED OVER - 15/09/2023		
INV/24/00462	Working elsewhere whilst sick	CARRIED OVER - 21/02/2024		
INV/25/02172	Working elsewhere whilst sick	CARRIED OVER - 14/07/2025		
INV/25/02716	False prescriptions printed	CARRIED OVER - 15/09/2025		
INV/26/00131	False prescriptions printed	CARRIED OVER - 15/01/2026		
INV/26/00890	Working elsewhere whilst sick	CARRIED OVER - 11/03/2026		
INV/26/00979	Accessing records	CARRIED OVER - 23/03/2026		
INV/26/01166	Overseas Patient	CARRIED OVER - 31/03/2026		
INV/26/01340	Prescribing irregularities	21/04/2026		

3. Significant Salary Overpayments

There has been one significant salary overpayment reported for this period. This has been reviewed by the counter fraud team and has not 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.

<table>
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Private</td><td>x
</td><td>Meeting Date:</td><td>19th May 2026</td></tr>
<tr><td>Status
(please tick one only):</td><td>Assurance</td><td></td><td>Approval</td><td>x</td><td>Information</td><td></td></tr>
<tr><td>Lead Executive:</td><td colspan="6">Catherine Phillips</td></tr>
<tr><td>Report Author (Title):</td><td colspan="6">Henry Bales
Counter Fraud Manager</td></tr>
</table>

Main Report
Background and current situation:

1. SITUATION

The NHS Counter Fraud Authority requires that an Annual work plan is created in relation to the counter fraud work to be carried out by counter fraud teams for their organisations. The workplan must directly align with Government Functional Standard GovS 013: Counter Fraud. This plan adheres to that principle and provides an overview of the areas of work that will be carried out on behalf of the organisation for 2026/27.

2. BACKGROUND

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services. The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and has a duty to ensure the effective implementation of the NHS Counter Fraud Requirements. Local Counter Fraud Teams must adhere to these requirements and report their work against them. As a result, an Annual Workplan identifying how these requirements will be met is produced and submitted to DoF and Audit Committee for their approval.

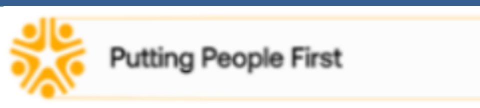
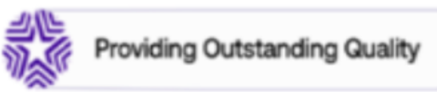
Executive Director Opinion and Key Issues to bring to the attention of the Committee:

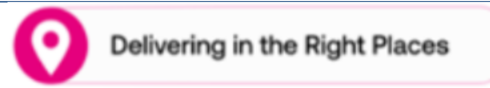
The plan has been approved and agreed by Executive Director Finance. Audit committee members are asked to review and approve the report.

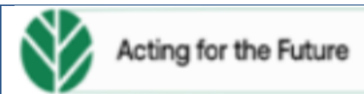
Recommendation:

The Committee are requested to: **Review, discuss and approve the Plan.**

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





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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Loss of public funds which has an effect on patient care
Safety: No
Financial: Yes
Loss of public funds which has an effect on patient care
Workforce: Yes
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes
Use Statutory legislation to conduct investigations
Reputational: Yes
All negative publicity undermines public confidence
Socio Economic: Yes/No
N/A
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Catherine Phillips	16/03/2026

NHS WALES
Cardiff and Vale University Health Board

COUNTER FRAUD WORK PLAN
2026/2027

Henry Bales
Manager Counter Fraud

This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Team in order to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Executive Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Henry Bales

Workplan agreed by:

Executive Director of Finance – Catherine Phillips

Date: 16/03/2026

WORKPLAN 2026-27

Countering fraud, bribery and corruption is fundamental to safeguarding the resources of Cardiff and Vale University Health Board. The threat of economic crime continues to evolve in both scale and complexity, driven by increasingly sophisticated methods, digital vulnerabilities, and operational pressures that can create opportunities for exploitation.

This Annual Counter Fraud Work Plan for 2026/27 sets out a comprehensive programme of proactive and reactive activity designed to strengthen the organisations' resilience against fraud. Cardiff and Vale University Health Board is required to comply with the Government Functional Standard 013: Counter Fraud (GovS 013), and compliance is assessed annually through a structured self-assessment process. To support continued compliance and provide assurance to senior management and the Audit and Corporate Governance Committee, all elements of this work plan are mapped directly against the requirements of GovS 013 as set out by the NHS Counter Fraud Authority (NHS Requirements | Government Functional Standards | NHS Counter Fraud Authority).

The NHS Wales Fighting Fraud Strategy (2026–2030) has been drafted and is expected to be approved for implementation during the 2026/27 financial year. In anticipation of this, the work plan has been aligned to the draft strategic framework. Accordingly, all planned activities for 2026/27 are organised under the five strategic pillars of the NHS Wales strategy:

- **Prevent** – strengthening systems and controls, reducing opportunities for fraud, and promoting awareness across all staff groups.
- **Detect** – using intelligence, data, and proactive work to identify anomalies and fraud risks early.
- **Respond** – investigating allegations effectively, applying appropriate sanctions, and recovering losses.
- **Build Capability** – ensuring the Local Counter Fraud Specialist (LCFS) function is skilled, accredited, and equipped to meet emerging threats.
- **Collaborate** – working in partnership with NHS bodies, NHS Counter Fraud Service Wales (NHSCFSW), the NHS Counter Fraud Authority (NHSCFA), and other stakeholders to ensure consistent, system-wide protection.

Together, these pillars provide a clear and coherent framework for delivering meaningful counter fraud outcomes. This plan outlines the specific activities, resource allocation, intended outputs and areas of priority for the year ahead. It is designed to be dynamic and responsive, enabling adaptations where emerging risks, intelligence or organisational needs require changes in approach. Through

this work plan, the organisation reaffirms its commitment to maintaining high standards of probity, strengthening public confidence, and ensuring that services provided to patients across Wales are protected from the harms caused by fraud.

Cardiff and Vale University Health Board (CAVUHB) has an in-house counter fraud team consisting of four full-time accredited counter fraud professionals, one Manager, one Deputy Manager and two Local Counter Fraud Specialists. The counter fraud team also provide services via formal service level agreements to four other NHS Wales organisations (Health Education and Improvement Wales, Digital Health and Care Wales, Velindre University NHS Trust and Public Health Wales). Each of these organisations has its own annual work plan agreed with their Director of Finance and Audit Committees, an overview of the days provided to these organisations is provided below.

Total Resource Provision

Resources Provided to each Organisations by CAVUHB Counter Fraud Team	Days Planned 2026/27	Approximate Whole Time Equivalent (WTE)
Cardiff and Vale University Health Board	505	2.30
Velindre University NHS Trust	100	0.45
Public Health Wales	100	0.45
Health Education and Improvement Wales	85	0.39
Digital Health and Care Wales	85	0.39
Total	**875**	**4.00**

Resource by Activity provided to CAVUHB

Activity	Days Planned 2026/27
Proactive	252.5
Reactive	252.5
Total	**505**

GovS 013 returns submitted annually to the NHSCFA require organisations to categorise counter fraud activity as either Proactive or Reactive.

Proactive activity includes work designed to prevent and deter fraud, such as fraud awareness training, corporate induction, development of e-learning, local proactive exercises, data analysis, and fraud risk assessments.

Reactive activity includes work undertaken in response to referrals and intelligence, such as investigations, evidence gathering, case management, and system weakness reporting arising from proven or suspected fraud.

The NHSCFA emphasises that Proactive work should not be absorbed by Reactive activity and strongly encourages organisations to ring-fence proactive days to maintain an appropriate balance between prevention and investigation. However, due to the dynamic and unpredictable nature of counter fraud work, this plan is designed to remain flexible and responsive to emerging risks, organisational priorities, and fluctuations in referral demand.

Where changes to the planned allocation of days are necessary, they will be discussed with the Executive Director of Finance at the earliest opportunity and reported to the Audit and Corporate Governance Committee. Any adjustments to overall days delivered or resourcing priorities will be reflected in quarterly progress updates and the end-of-year Annual Report.

Counter Fraud Activities for 2026/27

Below are set out the activities that the counter fraud department will complete on behalf of Cardiff and Vale University Health Board, these have been organised into the 5 new strategic areas from the NHS Wales Fighting Fraud Strategy. The activities have been mapped against the NHS Requirements/GovS 013.

PREVENT		
Assess the risk, strengthen systems and controls and promote awareness to stop fraud before it occurs.		
TASK / OBJECTIVE	**REQUIREMENT / STANDARD**	**PROPOSED DELIVERY**
Policy and Response Plan – This is in place within the organisation and sets out roles and responsibilities, reporting routes and processes within the organisation. Annual review of Counter Fraud, Bribery & Corruption Policy and Response Plan. (Policy has been updated and approved Q4 2025/26).	GovS 013 – Requirements 3 & 4	Q4
Fraud Risk Management Programme – Maintain a live Fraud Risk Profile using the GCFP methodology; record risks on DATIX/risk registers; time-bound follow-ups on mitigation actions.	GovS 013 – Requirements 2, 3 & 5	Throughout Year
Reporting Routes visibility & evaluation – Maintain local reporting route. Periodically review usage and reporting numbers. Conduct a survey during the year. Refresh publicity if gaps identified.	GovS 013 – Requirements 7 & 11	Throughout Year
DOI / Gifts & Hospitality Registers and Policy – Review of policy and completion rates. Review any high-risk records (combining with NFI matches where appropriate)	GovS 013 – Requirements 5 & 12	Throughout Year

Awareness Activity – Attend at all induction marketplace events held by the organisation. Provide awareness sessions to departments/directorates across the organisation in response to identified local needs/risks. Continue to promote the e-learning course and monitor completion rate. Sessions and e-learning aim to increase awareness of fraud, how it can occur, what to do if you suspect fraud and what potential consequences of fraud are.	GovS 013 – Requirements 7 & 11	Throughout Year
Lessons Learnt – Identify and disseminate lessons learned from investigations and proactive exercises.	GovS 013 – Requirements 3, 5 & 6	Throughout Year

DETECT		
Use data, intelligence and advanced analytics to help prioritise resources and link fraud risks early.		
TASK / OBJECTIVE	**REQUIREMENT / STANDARD**	**PROPOSED DELIVERY**
National Fraud Initiative – fully participate in the exercise. Ensure data is submitted and all organisational details are up to date. Ensure response and completion methodology meets best practice (Audit Wales Report expected during the year).	GovS 013 – Requirements 3, 5 & 10	Throughout Year
National and Local Proactive Exercises – Fully participate in any national proactive exercises as set out by NHSCFSW and NHSCFA. Plan and execute local exercises as identified from risk / incident trends or as directed by the organisation (Audit and Corporate Governance Committee or Executive Director of Finance).	GovS 013 – Requirements 3, 5 & 10	Throughout Year

Data Analytics – Identify and complete data analytics exercises locally or in partnership with NHSCFA Project Athena, where available.	GovS 013 – Requirements 3, 5 & 10	Throughout Year
Intelligence – Respond to intelligence reports and fraud prevention notices received. Ensuring appropriate action is taken for each report.	GovS 013 – Requirements 3 & 10	Throughout Year

RESPOND		
Investigate thoroughly, recover losses, and apply appropriate sanctions swiftly.		
TASK / OBJECTIVE	**REQUIREMENT / STANDARD**	**PROPOSED DELIVERY**
Investigations and investigation management – Conduct investigations in line with NHSCFA Fraud Manual and legal requirements. Investigation oversight and management to be provided by Manager/Deputy Manager. Seek appropriate sanctions for cases.	GovS 013 – Requirements 6, 8 & 9	Throughout Year
Recording and Reporting – Record all cases/activities, losses, recoveries, preventions and outcomes on CLUE, report to organisation through Audit and Corporate Governance Committee and report via quarterly Welsh Government returns and annually through government functional standard returns. Maintain record / data in a format compatible with various reporting requirements.	GovS 013 – Requirements 5, 6 & 8	Throughout Year
Response to Reports and Requests – provide timely response to reports of potential fraud, requests from external partners for assistance and requests for advice from Cardiff and Vale University Health Board staff.	GovS 013 – Requirements 6, 7 & 10	Throughout Year

BUILD CAPABILITY		
Invest in our people by providing specialist training and equipping counter fraud teams with latest tools and technology.		
TASK / OBJECTIVE	**REQUIREMENT / STANDARD**	**PROPOSED DELIVERY**
Maintain a fully accredited skilled team – Ensure staffing level is maintained at 4 fully accredited counter fraud specialists. Each member of the team to have a CPD and development plan. Maintain compliance with ESR mandated training. Attendance at NHS CFA/CFSW events and forums. Continue to monitor the development of the Government Counter Fraud Profession and the anticipated upcoming requirements for staff to obtain membership through completion of new training. Ensure training is obtained and completed when available.	GovS 013 – Requirements 9 & 11	Throughout Year
CLUE Competence and quality reviews – Monthly (minimum) reviews of quality and timeliness of CLUE entries. Target refresher training where needed.	GovS 013 – Requirements 5 & 6	Throughout Year
Tools and Equipment – Ensure that the team maintains access to appropriate workspace and equipment required for the role. Look at best practice and equipment predicted lifespans to ensure plans are in place to maintain and improve access to equipment and software. Ensure compliance with information governance standards.	GovS 013 – Requirement 9	Throughout Year

COLLABORATE		
Foster strong partnerships across NHS Wales, other Welsh public bodies, Welsh Government, and UK agencies such as HMRC and DWP to share intelligence and best practice.		
TASK / OBJECTIVE	**REQUIREMENT / STANDARD**	**PROPOSED DELIVERY**
Governance and Assurance – Regular meeting with Executive Director of Finance. Quarterly reports and presentation to Audit and Corporate Governance Committee. Meetings with Counter Fraud Champion, Audit Committee Chair and Independent Members as required. Executive Director of Finance is the nominated accountable board member and is nominated with the NHSCFA. Audit Committee Chair is nominated with the NHSCFA. Ensure nominations of DoF, ACC and counter fraud specialists is kept up to date.	GovS 013 – Requirements 1, 2, 5 & 6	Throughout Year
Outcome Based Metrics and Dashboard – Database maintained tracking all work undertaken by the counter fraud department on behalf of the organisation. Allowing for reviews of trends, investigations, proactive work and awareness work.	GovS 013 – Requirement 5	Throughout Year
Partnerships and Campaigns – Collaborate with key stakeholders regularly including Internal Audit, Workforce and OD and counter fraud colleagues. Attendance at Counter Fraud Liaison Groups and other national panels/groups (e.g. Counter Fraud Authority Stakeholder Engagement Group). Participate in International Fraud Awareness Week. Regular fraud newsletters and bulletins to be developed, promoted and circulated.	GovS 013 – Requirements 2, 3, 10 & 11	Throughout Year

Report Title:	Counter Fraud Annual Report 2025-26			Agenda Item no.	4.2.3
Meeting:	Audit & Assurance Committee	Public	x	Meeting Date:	19th May 2026
		Private			
Status *(please tick one only)*:	Assurance **x**	Approval		Information	x
Lead Executive:	Catherine Phillips				
Report Author (Title):	Henry Bales Counter Fraud Manager				

Main Report

Background and current situation:

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services. The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance with the NHSCFA's standards for providers, this annual report will also document and present the following details,

- Days used to deliver counter fraud, bribery and corruption work
- The cost of counter fraud, bribery and corruption work carried out during the year
- Details of any risk based proactive exercises conducted during the year
- The number of incident reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made.

The report also highlights how LCFS' has demonstrated compliance towards the recognised standards, with some of the key aspects summarised. The NHS CFA measures compliance as follows: Green – fully compliant; Amber – partially compliant; Red – non-compliant.

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

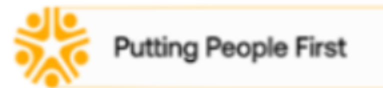
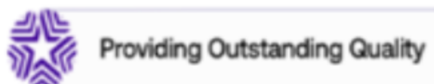
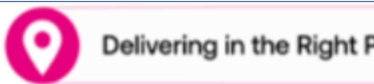
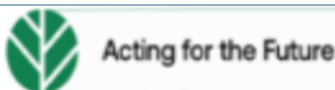
The report highlights the work completed by the counter fraud team for CAVUHB and other client organisations throughout the year.

Recommendation:

The Committee are requested to: note the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Loss of public funds which has an effect on patient care
Safety: No
Financial: Yes
Loss of public funds which has an effect on patient care
Workforce: Yes
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes
Use Statutory legislation to conduct investigations
Reputational: Yes
All negative publicity undermines public confidence
Socio Economic: Yes/No
N/A
Equality and Health: No
Decarbonisation: No

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

NHS WALES
Cardiff and Vale University Health Board (CAVUHB)

Annual Counter Fraud Report 01/04/2025 - 31/03/2026

HENRY BALES
COUNTER FRAUD MANAGER

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1. Introduction

This Counter Fraud Annual Report has been written in accordance with Welsh Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS) to provide a written report at least annually to Cardiff and Vale University Health Board (CAVUHB) on Counter Fraud work undertaken. All NHS organisations, in compliance with their service conditions of their NHS standard contract, must comply with the NHS Counter Fraud Authority's (NHSCFA's) fraud, bribery and corruption standards for providers.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance with the NHSCFA's standards for providers, this annual report will also document and present the following details.

- Days used to deliver counter fraud, bribery and corruption work.
- The cost of counter fraud, bribery and corruption work carried out during the year.
- Details of any risk based proactive exercises conducted during the year.
- The number of incident reports and cases recorded on the NHSCFA Case management system.
- Number and type of sanctions imposed, including recoveries made.

This report has been complemented throughout the year with detailed progress reports presented to the Audit and Assurance Committee. Following acceptance and approval by the Audit and Assurance Committee this Counter Fraud Annual Report will also be made available to the NHSCFA Quality Assurance and compliance team for review if requested.

For the purposes of this report, the term 'fraud' refers to a range of economic crimes, such as fraud, bribery and corruption or any other illegal acts committed by an individual or group to make a financial or professional gain, or to cause an economic loss.

The counter fraud department at CAVUHB also provide the counter fraud provision to four other NHS Wales organisations; Health Education and Improvement Wales, Digital Health and Care Wales, Velindre University NHS Trust and Public Health Wales. Throughout the report work will be detailed for CAVUHB and also the total work conducted for all five organisations.

2. Summary of compliance

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the Government Functional Standard GovS 013: Counter Fraud. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standards is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales Directors of Finance meeting in 2021.

Each year, the organisation must complete a self-assessment against the NHS Requirements, this is titled the Functional Standard Return. This is completed by the Counter Fraud Manager and signed off by the Executive Director of Finance, and the Audit and Assurance Committee Chair prior to submission. The deadline for submission is 31st May 2026.

The NHS CFA measures compliance as follows: Green – fully compliant; Amber – partially compliant; Red – non-compliant. The self-assessment provided below, is monitored and tested by the NHS Counter Fraud Authority by way of compliance visits to the local team.

For the 2025-26 financial year a draft of the self-assessment has been completed by the Counter Fraud Manager with green ratings in 11 of the 12 areas. Awareness has been assessed as amber at this time. This return is for CAVUHB only, each of the other organisations covered have their own assessments. This must be reviewed and approved by the Audit and Assurance Committee Chair and Executive Director of Finance prior to submission to the Counter Fraud Authority. This must be completed by the deadline date of the 31st May 2026.

3. Allocation of Resources

At 31st March 2026 **505** days of Counter Fraud work have been completed against the agreed 505 days in the CAVUHB Counter Fraud Annual Work-Plan for the 2025/26 financial year as shown below. A further 370 days have been provided to the other organisations covered (Total: 875 days for the year). The days have been utilised across all areas of work. Including investigating allegations of fraud; preparing and delivering fraud awareness sessions, preparing for and attending Audit and Assurance Committee meetings; and carrying out fraud risk work.

Strategic Requirements CAVUHB	50 Days
Strategic Requirements Total	130 Days

(inclusive of corporate governance undertaking, attendance of departmental team at staff training events, report writing, planning and attendance all Wales meetings.)

Proactive Work CAVUHB	175 Days
Proactive Work Total	315 Days

(inclusive of fraud awareness sessions, and publicity work such as newsletters and bulletins, system weakness reviews and reporting, Local Proactive work. NHSCFA procurement exercise, and National Fraud Initiative work.)

Reactive Work CAVUHB	280 Days
Reactive Work Total	430 Days

(inclusive of the investigation of all referrals, attendance at court hearings, preparation of reports for disciplinary processes, preparation of reports for professional body investigations.)

4. Summary of Costs to the Organisation

Cost CAVUHB	**£ 162,238**
Total Charges to four organisations	**£ 118,900**
Total Cost	**£ 281,138**

5. Breakdown of Investigative work areas

During this financial year CAVUHB have received 148 new referrals these have been reviewed and investigated by the team. A further 81 referrals were dealt with by the team for the other organisations covered.

CAVUHB carried over 13 investigations from the 2024-25 financial year, 35 investigations were opened for CAVUHB in the year and 38 were closed, resulting in 10 investigations being carried over for CAVUHB to the 2026-27 financial year.

Across the other four organisations, 1 investigation was carried over from 2024-25 financial year, 13 investigations were opened and 10 investigations were closed. 4 investigations have been carried over to the 2026-27 financial year.

In total the department dealt with 229 referrals, opened 48 new investigations, closed 48 investigations and have carried 14 investigations over to the 2026-27 financial year.

The table below shows the case outcomes for the financial year 2025-26.

	CAVUHB	HEIW, VUNHST, PHW, DHCW	Total
Fraud Prevented Figure	**£3,230**	**£114,931**	**£118,161**
Fraud Loss Figure	**£5,433**	**£0**	**£5,433**
Fraud Recovery Figure	**£5,433**	**£0**	**£5,433**
Non-Fraud Loss Figure	**£2,873.89**	**£0**	**£2,873.89**
Non-Fraud Recovery Figure	**£2,633.89**	**£0**	**£2,633.89**
Civil Actions	**1**	**0**	**1**
Internal Disciplinaries	**9**	**0**	**9**

6. Fraud Awareness

The counter fraud department present at a number of events throughout the year including induction marketplaces, corporate induction presentations, student inductions and specific departmental talks. The breakdown of work completed in the 2025-26 financial year is shown in the table below:

	CAVUHB	HEIW, VUNHST, PHW, DHCW	Total
Number of Awareness Sessions	**11**	**35**	**46**
Number of Persons in Attendance	**520**	**1232** (this includes students funded by HEIW)	**1,752**

Ten newsletters and online bulletins were published in the financial year covering all five organisations.

Counter fraud E-learning remains available for staff to complete within the organisation. This is not currently mandated, and completion rates are low. An SBAE was submitted to the Education, Culture and Organisational Development department within the financial year to request they consider mandating counter fraud e-learning.

7. Fraud Risk Assessments/FPN Response

During the course of the year a Fraud Risk Profile for each organisation has been maintained. It is intended to be a live document subject to continuous review, a full review of each is planned for Q1 2026/27. The profile will inform future detection and compliance activity via the use of Local Proactive Exercises. The Fraud Risk Profile details the risks identified as inherent to the organisation as identified by the NHS Counter Fraud Authority and the Local Counter Fraud team. Local/Specific risks will be added to the profile as they arise. These will be informed externally by Fraud Prevention Notices and intelligence from other agencies and organisations; and, internally, from identified system weakness reporting post/during investigation work.

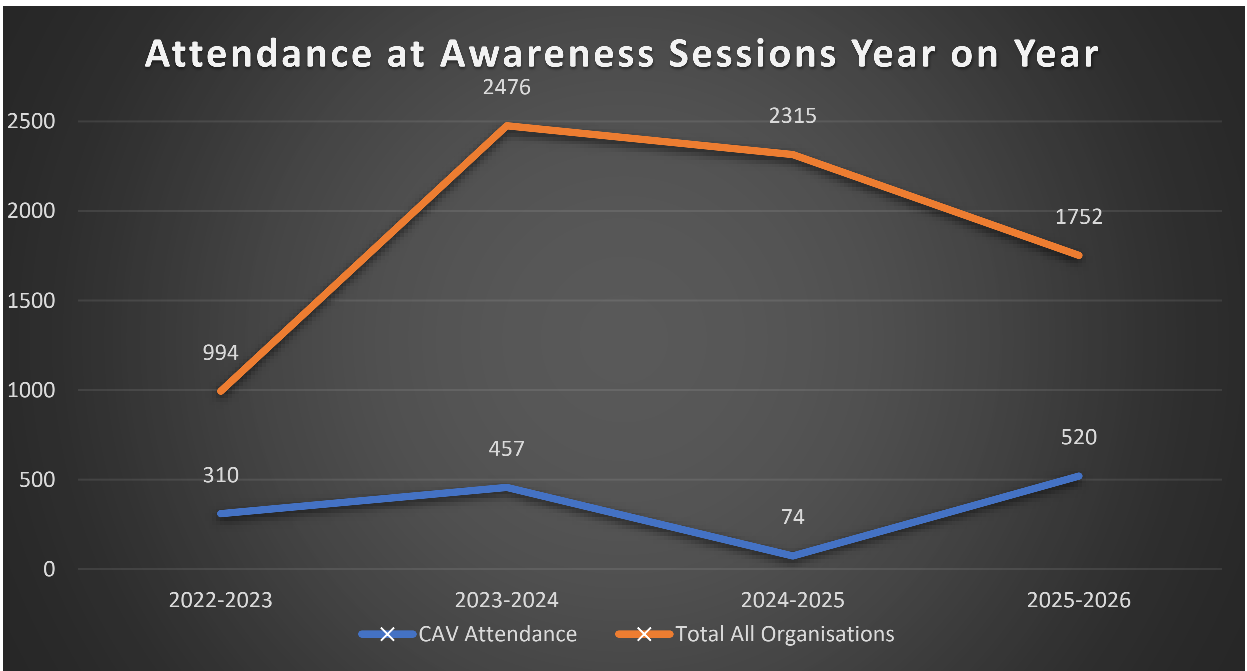
During this year the counter fraud department has responded to 14 fraud prevention notices/intelligence reports for CAVUHB (of these 11 were also relevant to the other organisations covered and relevant work was conducted for each organisation on these). Each one of these has been reviewed from the organisations perspective and any relevant response has been undertaken. Details

of these were provided through the year to the Audit and Assurance Committee via progress reports.

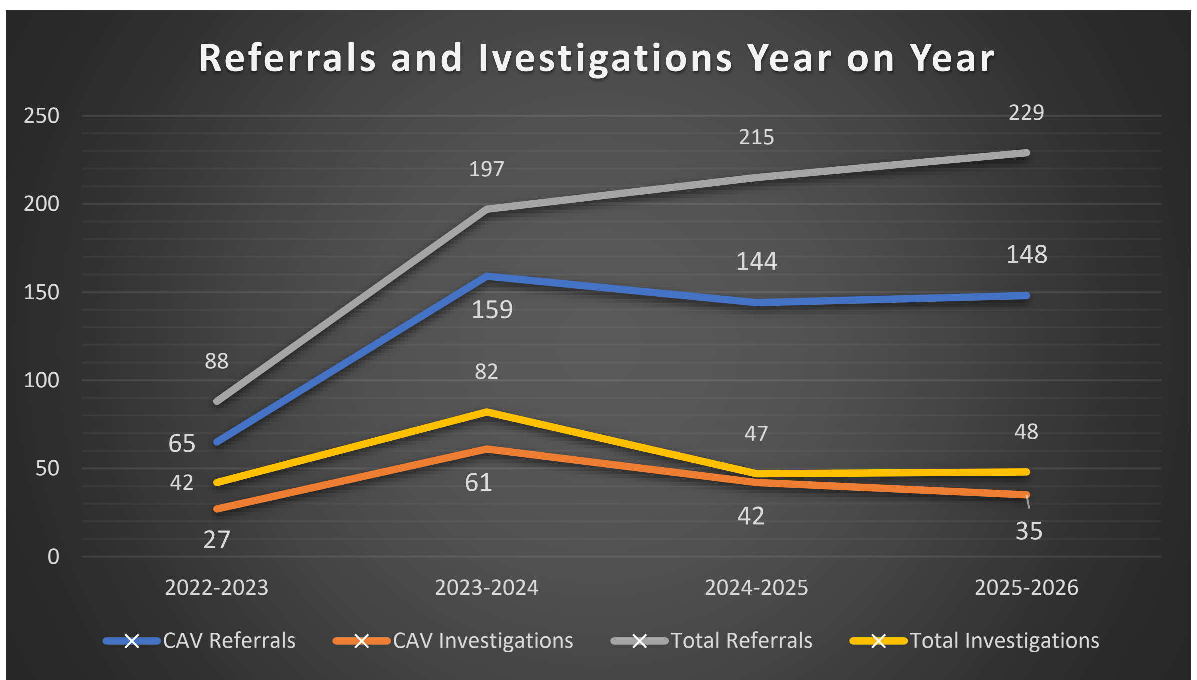
Four system weakness report were completed in the financial year for CAVUHB. One of these was also relevant to the other organisations covered and was completed for them also.

Three local proactive exercises (LPE) are open and ongoing for CAVUHB at the end of the financial year. Each of the other organisations also have one LPE each open and ongoing at the end of the financial year.

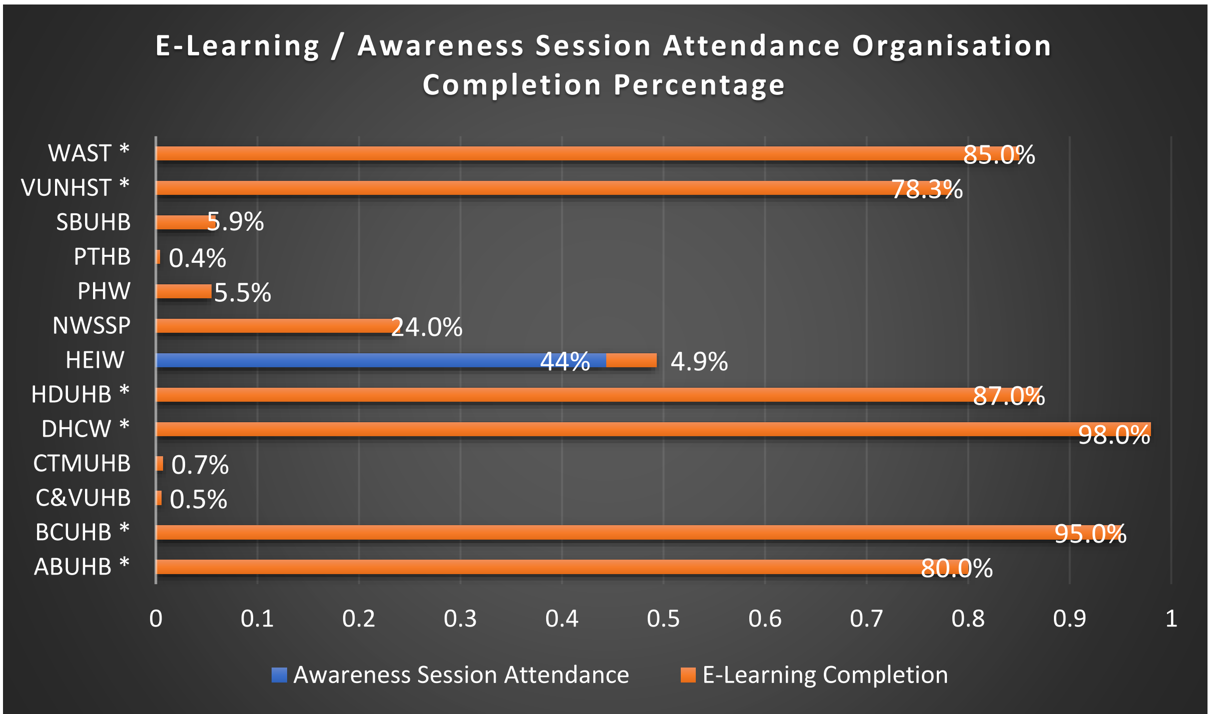
8. Performance Charts, Benchmarking and Analytics



Analysis:
Internal staff presentations have shown a pleasing rise in this financial year for CAVUHB. The decline in total numbers attendance is due to some organisations mandating e-learning and a reduction in students receiving presentations in this financial year.



Analysis:
Referrals for CAVUHB have remained stable for the past 3 years. However, the total referrals dealt with by the team have shown a steady continued increase in that time. Investigations have shown a slight decrease for CAVUHB in this year which is a trend continuing from the previous year. Overall, for the department investigations have remained stable following a drop from the 2023-24 year. This decrease is due to the reduction in overpayment of salary cases since this time.



Analysis:
This chart shows the completion percentage for e-learning within each NHS Wales Organisation. Organisations that have mandated awareness are indicated with “*” showing high levels of compliance.

One NHS Wales organisation (HEIW) has implemented a programme of promoting and strongly encouraging attendance at in-person/teams awareness sessions and recording these on ESR, this has been in place for approximately one year. This is shown in blue.

CAVUHB have not mandated e-learning and have one of the lowest completion percentages in NHS Wales. A paper has been submitted to ECOD requesting this position be reviewed. Over the past 3 years (this is the revalidation timeframe for e-learning) there have been 1051 staff members given awareness training, this would be roughly 6% of the organisation.

Referral Type

A breakdown of the referral type for CAVUHB is shown below. Due to some lower numbers in certain categories changes can appear significant with only small changes. The most significant changes of note are highlighted in the table.

Referral Type	2024-25	2025-26	% Change
Procurement Fraud	3	4	33%
Bursary Fraud	1	0	-100%
CV/Application Issues	0	1	N/A
Primary Care Contractor Fraud	7	3	-57%
Leave Fraud	2	1	-50%
Mandate Fraud	2	0	-100%
False Sickness Fraud	3	3	No Change
Working Elsewhere Whilst Sick	11	25	127%
Working Elsewhere in Contracted Time / Dual Employment	2	6	200%
Overseas Patient	2	3	50%
Patient - False Details	1	3	200%
Cyber / Scams	22	14	-36%
Timesheet / Overtime Fraud	2	11	450%
Expenses Fraud	1	0	-100%
Impersonating A Medical Professional	2	3	50%
Overpayments	35	15	-57%
Theft	10	13	30%
Recruitment Concerns	2	5	150%
Credit / Payment Card Fraud	1	0	-100%

Requests	18	13	-28%
Patient - Optical Claims	8	2	-75%
Data Handling	0	5	N/A
Other	2	11	450%
Prescription Fraud	7	7	No Change

Data covering the five organisations covered by the counter fraud department has also been analysed to show wider trends in referral type. These show broadly similar trends to CAVUHB only data.

Referral Type (All organisations)	2024-25	2025-26	% Change
False Sickness	3	6	100%
Working Elsewhere Whilst Sick	13	26	100%
Working Elsewhere in Contracted Time	4	13	225%
Overpayments	42	18	-57%
Recruitment	2	8	300%

9. Lines of Reporting

CEO – Suzanne Rankin

Executive Director of Finance – Catherine Phillips

Counter Fraud Manager – Henry Bales

Deputy Counter Fraud Manager – Steven Betty

LCFS – Jacob Parkinson

LCFS – Rhidian McCann

10. Declaration

I declare that the Counter Fraud work carried out on behalf of Cardiff and Vale University Health Board for the year 2025-2026 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard GovS 013).

Henry Bales
Counter Fraud Manager

Date: 27/04/2026