AUDIT AND ASSURANCE COMMITTEE

Tuesday 3 November 2026 at 09:00am

PUBLIC MEETING HELD VIA MS TEAMS – CLICK TO JOIN

09:00	**1. Preliminaries**		
1.1	**Welcome, Introductions & Apologies for Absence:**		David Edwards
	Introductions: Lianne Morse (for Rachel Gidman) Rhys Andrews (for Audiology Referral & Waiting List Audit)	**Apologies:** Rachel Gidman	
1.2	Declarations of Interest		David Edwards
1.3	Minutes of the Committee meetings held: 01.09.2026		David Edwards
1.4	Actions following meeting held: 01.09.2026		David Edwards
1.5	Any Other Urgent Business		David Edwards
09:10	**2. Items for Review & Assurance**		
09:10 2.1 30 mins	Internal Audit Progress Report including: • *Audiology Referral & Waiting List Management - Limited* • *Development of the Clinical Services Plan - Substantial* • *Automation / AI - Reasonable* • *Infection Prevention & Control – Reasonable* • *CD&T CB Governance and Financial Arrangements - Reasonable*		Ian Virgil Rhys Andrews
09:40 2.2	Audit Wales Update		Audit Wales

20 mins		
10:00 2.3 15 mins	Risk Management	Matt Phillips
10:15 2.4 10 mins	Procurement Compliance Report	Catherine Phillips
10:25	**3. Items for Approval/Ratification**	
	No items	
10:25	**4. Items for Noting & Information**	
4.1	Counter Fraud Progress Update	Henry Bales
10:25	**5. Agenda for Private Audit and Assurance Committee**	
	i. Approval of Minutes *ii. Audit of Accounts Report Addendum* *iii. Counter Fraud Progress Update (Confidential – ongoing investigations)* *iv. People & Culture Assurance Report*	
10:25	**6. Any Other Business**	
10:25	**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 2 February 2027	David Edwards
7.3	**5-minute break prior to Private Session**	

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

Minutes of the Public Audit & Assurance Committee Meeting Held On 01 September 2026 at 9:00am

Via MS Teams

To view a recording of this meeting, please click here.

Chair:		
David Edwards	DE	Committee Chair & Independent Member for ICT
Present:		
Ceri Phillips	CP	Vice Chair of the Health Board
Clive Curtis	CC	Independent Member – Community
In Attendance:		
Henry Bales	HB	Lead Local Counter Fraud Specialist
Claire Beynon	CB	Executive Director of Public Health
Anna Roger	AR	Senior Performance Auditor
Hannah Jones	HJ	Senior Auditor
Jeff Brown	JB	Audit Wales
Rachel Freitag	RF	Audit Manager – Audit Wales
Melanie Goodman	MG	Audit & Assurance Audit Manager
Lucy Jugessur	LJ	Deputy Head of Internal Audit
Robert Mahoney	RM	Deputy Director of Finance
Urvisha Perez	UP	Audit Lead - Audit Wales
Matt Phillips	MP	Director of Corporate Governance
Frankie Ogden	FO	Head of Corporate Governance
Angela Parratt	AP	Director Of Digital Transformation
Ian Virgil	IV	Head of Internal Audit
Claire Whiles	CWH	Assistant Director of OD, Wellbeing and Culture
Catherine Wood	CW	Deputy Chief Operating Officer
Amanda Legge	AL	All Wales Post Payment Verification Manager
Helen James	HJ	Head of Procurement
Sara Jeremiah	SJ	Post Payment Verification Location Manager
Gareth Stallard	GS	Deputy Head of Operational Procurement
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Chris Bown	CB	Chief Executive Officer
Rachel Gidman	RG	Executive Director of People and Culture
Catherine Phillips	CPH	Executive Director of Finance
Kirsty Williams	KW	UHB Chair

Item No	Agenda Item	Action
A&A 26/09/1.1	**Welcome, Introductions & Apologies for absence** David Edwards (DE), the Independent Member for ICT and Committee Chair welcomed everyone to the meeting and apologies for absence were received.	
A&A 26/09/1.2	**Declarations of Interest** None were raised. **The Committee resolved that:** a) No Declarations of Interest were noted.	

A&A 26/09/1.3	**Minutes of the Committee meeting held 19.05.2026 & 23.06.2026** The minutes of the meeting held on the 19.05.2026 were received. Clive Curtis (CC), Independent Member – Community noted that he had been at the meeting and asked for an action to be checked. The minutes of the meeting held 23.06.2026 were received. **The Committee resolved that:** a) The minutes of the meetings held on 19.05.2026 were deemed to be a true and accurate record of the meeting pending the amendments identified. b) The minutes of the meeting held on 23.06.2026 were deemed to be a true and accurate record of the meeting.	
A&A 26/9/1.4	**Actions following meeting held: 03.02.2026** The Actions were received. It was noted that all actions had been moved to the Forward Plan or marked as completed. **The Committee resolved that:** a) The Actions were noted	
A&A 26/09/2.1	**Internal Audit Progress Report** The Committee received the Internal Audit Progress Report, presented by Ian Virgil (IV), Head of Internal Audit, and supported by Lucy Jugessur (LJ), Deputy Head of Internal Audit. At the request of the Chair, the reports which had received Limited or Unsatisfactory Assurance were considered first. The papers were taken as read, with the principal findings and management responses highlighted. **Flexible Working Arrangements** LJ presented the Flexible Working Arrangements audit, which had received Limited Assurance, with four high-priority and three medium-priority findings. The audit had found that flexible working request forms were not consistently completed, retained or approved in accordance with policy requirements; flexible working arrangements were not comprehensively recorded on ESR; a significant number of requests had no recorded outcome or remained pending beyond policy timescales; and annual leave and bank holidays were not always recorded against the actual working patterns of staff working compressed hours. Catherine Wood (CW), Deputy Chief Operating Officer, advised that the audit had provided a helpful baseline against which operational arrangements could be improved. Clinical Boards would identify staff working formal compressed or variable hours, validate each arrangement with the relevant manager and employee, confirm the approval process, working pattern and review status, and ensure arrangements were formally documented within ESR. Annual leave and bank holidays would also be recorded against the hours normally worked. Local assurance checks would be introduced within directorates and Clinical Boards, with delivery monitored through the Clinical Board review process. A target completion date of 31 October 2026 had been agreed. Claire Whiles (CWH), Assistant Director of OD, Wellbeing and Culture, advised that the Health Board had implemented the All-Wales Flexible Working Policy and had established guidance, toolkits and training for managers. She explained that the audit had highlighted inconsistent implementation rather than an absence of policies or resources.	

CWH confirmed that a multidisciplinary Task and Finish Group had been established, involving People Services, Organisational Development, Trade Union representatives, e-Rostering, People Analytics and operational colleagues. The group was due to meet on 14 September 2026 to agree delivery of the audit actions and monitor progress.

Targeted support would initially focus on the Medicine Clinical Board, with People Services and business partners working directly with managers requiring additional assistance.

CWH also advised that a Leadership and Management Framework was being developed to clarify the accountabilities, responsibilities and development requirements associated with core management roles.

Matt Phillips (MP), Director of Corporate Governance, queried whether ESR automatically adjusted annual leave where staff worked compressed hours.

CWH initially advised that further work was required with the ESR and Workforce Analytics teams because working-pattern calculations were not always reflected correctly. She later clarified that ESR automatically adjusted annual leave entitlement where contracted hours changed, but issues could arise where contracted hours remained unchanged and the employee's working pattern changed.

Clive Curtis (CC), Independent Member - Community welcomed the proposed training and establishment of the Task and Finish Group and **requested that the Committee receive an update on its work at the next meeting.**

CWH agreed to provide an update.

DE questioned how the Health Board would determine whether training had been effective, rather than simply confirming that training had been delivered. He asked how the impact of the training would be monitored and reported to the Committee.

CWH advised that the developing management framework would support evaluation of whether practice had changed following training and would enable managers to be held to account for consistent implementation. Informal audits and follow-up discussions would also be used to monitor compliance.

DE further requested that a future update explain the relationship between the Leadership and Management Framework, appraisal arrangements and, where management requirements continued not to be met, the disciplinary process.

CWH emphasised the importance of the multidisciplinary nature of the Task and Finish Group. She noted that training resources were already available, but the audit indicated that these were either not being accessed or were not achieving the required effect. She advised that targeted support from business partners, delivered directly with managers, would provide a more effective approach. Compliance with ESR requirements would provide an objective measure of the effectiveness of the improvement work.

CWH advised that People Services had limited capacity to deliver additional training because the team was currently prioritising work relating to managing attendance. An options appraisal was therefore being developed, following discussion with the Chief Operating Officer, to ensure that available resources were directed towards the highest-priority areas.

Reducing Health Inequalities

IV presented the Reducing Health Inequalities audit, which had received Unsatisfactory Assurance, with five high-priority and one medium-priority finding.

The audit had reviewed the Health Board's arrangements for collecting ethnicity data and using that information to identify and reduce health inequalities. It had identified fundamental weaknesses in governance, data quality and the use of ethnicity data.

IV advised that the Health Board was unable to demonstrate effectively how ethnicity data was being used to identify and address health inequalities, despite the reduction of health inequalities being a strategic objective and a risk identified within the Board Assurance Framework.

The audit had found that there was no comprehensive register of systems collecting ethnicity data, no formal training or guidance for staff, unclear ownership and accountability, and no established quality-assurance framework to ensure that data was complete and accurate. Ethnicity data was fragmented across multiple systems, with limited integration, analysis or reporting through the Health Board's governance arrangements.

Claire Beynon (CB), Executive Director of Public Health, acknowledged that the outcome was disappointing but not entirely unexpected. She advised that she had requested the review because the organisation needed to demonstrate and measure progress against its strategic commitment to improve population health and reduce unfair differences in health outcomes.

CB confirmed that the findings had been discussed at Management Executive Meetings and that delivery of the actions required a collective response across the organisation.

Actions had been assigned to the Director of People and Culture, Chief Operating Officer, Medical Director, Director of Digital and other relevant Executive Leads, all of whom had committed to progressing their respective elements of the improvement work. Ceri Phillips (CP), Vice Chair of the Health Board, expressed disappointment at the findings and emphasised the urgency of delivering the actions. He noted that reducing health inequalities was a commitment of the Board and that, without reliable data and intelligence, the Health Board would be unable to demonstrate progress against its strategic objectives.

CP acknowledged that collecting ethnicity information could be difficult but stressed that mechanisms were available to improve data collection. **He requested that progress be considered through the Quality Committee and that a future follow-up review be undertaken to provide assurance that the position had improved**.

DE agreed that the findings reinforced the importance of improving the quality of the Health Board's data and intelligence. He welcomed the allocation of actions to the Director of Digital, noting that improved data would support more informed decision-making and provide greater assurance regarding progress in reducing inequalities.

Follow-ups Not Booked (From 25/26 plan) (Limited Assurance)
LJ presented the Follow-Ups Not Booked audit, which had received Limited Assurance, with four high-priority and two medium-priority findings.

The audit had reviewed the arrangements for managing patient follow-ups and identifying patients who might have been lost to the follow-up process. Whilst systems, processes and governance arrangements were in place, these were not operating consistently or effectively to ensure that patients were identified, monitored and progressed in a timely manner.

The audit had found that there was no current Health Board-wide Standard Operating Procedure for managing Follow-Ups Not Booked, with outdated guidance resulting in variation across specialties and directorates. Follow-up lists were not reviewed and monitored routinely because of capacity pressures and the continued focus on Referral to Treatment performance. Clinic outcomes were recorded inconsistently, which prevented the timely progression of patient pathways, and the follow-up datasets contained significant inaccuracies.

LJ advised that audit testing had found that 84% of the sampled pathways were invalid and should no longer have appeared on the follow-up lists, 11% contained data-quality issues and only 5% represented genuine Follow-Ups Not Booked.

CW acknowledged that the process was complex and advised that the management response comprised two principal elements: strengthening processes and controls, and increasing capacity to ensure that patients were seen appropriately.

A revised Health Board-wide Standard Operating Procedure had been developed and was being tested with operational teams, with the intention that it would be embedded as business as usual by the end of October 2026. Follow-Ups Not Booked were now reviewed weekly by the Operational Delivery Group, chaired by the Chief Operating Officer, with Executive oversight of Follow-Ups Not Booked and uncashed clinics provided through the Productivity and Efficiency Meeting.

CW advised that the Clinical Outcome Form had been revised to make it more user-friendly and a business intelligence report was issued weekly to directorate managers, identifying uncashed clinics requiring action. This would allow teams to address outstanding activity in manageable increments and prevent the backlog from continuing to grow.

To address capacity and validate the existing backlog, approximately 17,000 patients would be contacted by text message and offered a See on Symptoms pathway. The exercise would identify patients who wished to be seen and support the removal of patients who no longer required routine follow-up. A programme was also being implemented to overbook clinics where the Did Not Attend rate exceeded 5%, which was expected to release approximately 7,000 additional outpatient appointments. Those appointments would be allocated between outstanding follow-ups and new Referral to Treatment patients, with the balance of risk reviewed weekly.

CW advised that a longer-term digital, end-to-end patient management solution was required to bring patient administration and communications together. The Digital and Health Intelligence Directorate had begun considering the available options, which would require further resource discussions during the next financial year.

DE expressed concern about the patient-safety and health-inequality implications of relying on patients to respond to text messages, particularly where patients were digitally excluded or had circumstances which made engagement more difficult. He sought assurance regarding the removal of patients from follow-up lists where no response had been received.

CW advised that the See on Symptoms approach was consistent with practice elsewhere in Wales and England and provided a means of contacting patients who might otherwise receive no communication because of capacity constraints. She reiterated that audit testing had indicated that a substantial proportion of patients should no longer have been included on the follow-up lists and considered that the approach would provide a proportionate safety net for the majority of patients.

CP acknowledged the concern and emphasised the need to balance the risks involved. He supported the See on Symptoms approach as a more modern and efficient model but stressed that the booking and communication processes needed to ensure that patients understood how to seek follow-up care if symptoms arose.

IV then presented the routine progress update on delivery of the 2026/27 Internal Audit Plan.

He advised that the audit relating to Artificial Intelligence and Automation had not been finalised in time for the meeting because of the volume of fieldwork and meetings required. The fieldwork had since been completed, the report had been issued in draft and it would be presented to the next Committee meeting.

The Committee was advised that the revised plan comprised 40 audits. At the time of the meeting, two audits had reached final report, one had been issued in draft, seven were in progress and ten were at the planning stage.

IV highlighted that one management response had not been received within the required 15-working-day period. As this related to one of only a small number of completed audits at that stage of the year, the relevant performance indicator had moved into a red position. IV advised that the measure was affected by the small sample size but confirmed that performance would continue to be monitored, with any significant issues raised with the Corporate Governance Team, relevant Executive Leads and the Committee.

IV outlined proposed amendments to the plan, comprising the removal of three audits and the addition of seven. Three additions related to follow-up work arising from previous Limited and Unsatisfactory Assurance reports, one related to the Health Board's Grip and Control Self-Assessment, and three related to capital schemes. He confirmed that the capital scheme audits would be funded separately through the relevant business cases.

The Committee received the conclusions and assurance ratings for the remaining audits finalised during the reporting period:

Leadership and Management Training and Development: Reasonable Assurance, with a number of findings identified for management attention.

Five Steps of Safer Surgery: Reasonable Assurance overall. CP expressed concern that this rating could convey the wrong message when the report stated that the Health Board had reaffirmed zero tolerance of non-compliance, whilst also finding that theatre care-plan checklists were not always completed fully and signed off at each stage. He noted the connection with previous Quality Committee concerns regarding theatre compliance and never events.

IV acknowledged the challenge and explained that the overall rating represented the balance across three audit objectives. One objective, relating to day-to-day compliance with the Five Steps of Safer Surgery, had received Limited Assurance and included two high-priority findings. He confirmed that further work remained necessary to secure consistent compliance.

MP noted that the target dates for the associated actions had passed. **He proposed that progress be followed up with the Surgery Clinical Board and included within the AAA report to the Quality Committee**. CP supported this approach, noting that it

	would provide the Quality Committee with visibility of both the audit report and progress against the actions. **Medicines Management:** Reasonable Assurance, with management actions agreed to address the findings identified. **Local and Shadow IT Systems**: Reasonable Assurance overall, although the rating was described as being at the lower end of Reasonable Assurance. A number of high-priority findings had been identified and one audit objective had received Limited Assurance. DE highlighted the difficulty of obtaining comprehensive visibility of local and shadow IT systems and the associated information-governance, cyber-security and procurement risks. He suggested that the matter should continue to be monitored through the Digital and Infrastructure Committee. IV agreed that comprehensive oversight remained a challenge and noted that similar issues had arisen in previous audits, including challenges relating to local governance and available resources. **Space Utilisation: Advisory Review**. No assurance rating had been issued. The review identified weaknesses and opportunities to strengthen arrangements for managing the use of space, with management actions agreed where appropriate. **Speaking Up Safely:** Reasonable Assurance. The audit recognised the arrangements currently in place but identified the need to improve awareness and ensure that the process was used appropriately when required. **Purchasing of Stock and Equipment within the ALAS Service**: Reasonable Assurance, with actions agreed to strengthen processes and improve supporting systems. **The Committee resolved that:** A) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered. B) The proposed adjustments to the 2026/27 plan were approved.	
A&A 26/09/2.2	**Thematic Review Internal Audit** The Committee received the Internal Audit Thematic Review, presented by IV. The review used a Power BI database containing publicly available Internal Audit outcomes and findings from Cardiff and Vale UHB and other NHS Wales organisations to identify trends and support future audit planning. IV reported that more than 190 audits had been undertaken for the Health Board over the previous six years. While most had received Reasonable Assurance and Cardiff and Vale's position was broadly consistent with the All-Wales average, there had been a slight increase in Limited Assurance reports and a reduction in Substantial Assurance reports. DE questioned whether this represented a deterioration in performance or reflected the deliberate targeting of Internal Audit activity towards higher-risk areas. IV advised that it was likely to be a combination of both, noting that Limited Assurance outcomes could demonstrate that audits were being directed towards areas where management required greater assurance.	

	MP agreed that Internal Audit was generally directed towards areas where assurance was uncertain or which had not been reviewed recently. IV also highlighted the Health Board's increasing use of Advisory Reviews to support the development and improvement of services and processes. The areas with the highest levels of Limited Assurance were Workforce Management, Operational Services, Information Governance and Clinical Governance. A total of 834 findings had been raised, of which 141 were high priority. The analysis found that 60% related to the operation of existing controls rather than their design, indicating that processes were often in place but were not applied consistently. Governance and Information and Data Quality were the most common themes. Governance findings included outdated Terms of Reference and weaknesses in meeting, minute and action-tracking arrangements, while data-quality findings related mainly to missing, incomplete or inconsistently recorded information. MP welcomed the review and noted that the governance analysis would be useful when considering the Health Board's operating model, including how assurance, reporting and decision-making arrangements worked in practice. IV confirmed that further analysis could be provided if the Committee identified specific areas for future consideration. IV offered to undertake further thematic analysis and provide additional reports to future meetings should the Committee identify areas requiring further exploration. **The Committee resolved that:** A) The trends and themes highlighted through the analysis of the outcomes of previous Internal Audit work were considered.	
A&A 26/09/2.3	**Audit Tracker Report** The Audit Tracker Report was received and presented by MP. He advised that the Health Board received numerous audits, inspections and regulatory reviews each year, resulting in hundreds of associated actions. The report provided transparency on the nature of those actions and the arrangements in place to monitor delivery, including actions arising from Internal Audit, Audit Wales, HEIW and other regulatory reviews. It was reported that a significant proportion of Internal Audit and Audit Wales actions remained overdue. MP acknowledged that, although actions were being completed over time, they were not always delivered within the agreed timescales. He advised that this could reflect competing priorities and insufficient capacity to deliver the actions, or the agreement of deadlines that had not been realistic at the outset. He confirmed that the Corporate Governance Team would strengthen its existing monthly scrutiny of overdue actions. Relevant information would be incorporated into Clinical Board Reviews to hold Clinical Boards to account for delivery, with a parallel mechanism developed for actions assigned to Executive and corporate areas. DE welcomed the proposed approach and suggested further consideration be given to how the Committee could use the report regularly to maintain focus on high-priority actions. Whilst recognising the operational pressures affecting delivery, he stressed that the Committee required assurance that high-priority findings were being addressed within realistic timescales.	

	MP confirmed that he would assess the impact of the revised monitoring arrangements and provide an update to the Committee in February 2027. **The Committee resolved that:** A) The information relating to Internal Audit & Audit Wales actions and the revised performance management approach that would be taken to reduce the overdue actions was noted. B) The regulatory audit tracking overview was noted.	
A&A 26/09/2.4	**Audit Wales Update** The Audit Wales Update was received and presented by Rachel Freitag (RF), Audit Manager, and Urvisha Perez (UP), Audit Lead. RF advised that there had been limited financial audit activity since the certification and laying of the Health Board's 2025/26 Annual Accounts in June 2026. Planning and interim testing for the 2026/27 accounts audit would take place during the autumn and winter. Audit work on the 2025/26 Charitable Funds Accounts would also be undertaken, with certification intended by the end of January 2027 in line with the Charity Commission deadline. UP reported that the Clinical Coding, Local Cancer Services and Digital Transformation reviews had been completed and were included within the Committee papers. The draft Estates Management report had been issued to the Health Board for clearance and was expected to be presented to the Committee in November 2026. It was noted that the 2026 Structured Assessment was underway, with greater emphasis being placed on organisational effectiveness and impact. It would assess delivery of the Health Board's 2025/26 Annual Plan and the impact of planned actions on finance, performance and outcomes. It would also follow up outstanding recommendations and gather high-level intelligence regarding hosted bodies and joint committees. Planning was also progressing for reviews of Diabetes Management and Operating Theatre Efficiency and Effectiveness. UP drew attention to recently published Audit Wales insight reports on planned care and urgent and emergency care and advised that Catherine Whelan-Jones had taken up post as Auditor General for Wales. Clinical Coding Progress Review CP referred to observations made during a visit to the Medical Records Department at University Hospital of Wales. He expressed concern regarding the timeliness of clinical coding and the potential quality, patient-safety and follow-up implications. He also questioned the continued retention of paper records following digitisation, particularly given the condition of the accommodation in which records were stored. **Clinical Coding Progress Review:** Hannah Jones (HJ), Audit Wales Senior Auditor, presented the Clinical Coding Progress Review, which assessed delivery against outstanding recommendations from the 2014 and 2019 reviews. She reported that progress had been made through clearer management arrangements, improved workforce stability and team culture, investment in staff development and continued visibility of clinical coding at Board level. However, further improvement was required in relation to coding performance, workforce vacancies, medical records, clinical engagement, improvement planning and Board oversight.	

Six new recommendations had replaced the previous outstanding recommendations. These focused on collaboration and shared learning between coding teams across sites, updating policies and procedures, strengthening shared responsibility with clinical services, improving Board oversight, introducing a business-partnering model and developing a coordinated Clinical Coding Improvement Plan. Management had accepted all six recommendations.

CW welcomed the review and reported that coding completion had improved to 83% for April 2026 and 84% for May 2026. Shared learning and cross-site working arrangements were now in place. CW acknowledged continuing workforce challenges and advised that more junior staff were being recruited through a structured training and progression programme to develop the Health Board's own clinical coding workforce.

Are Cancer Services Improving?
Anna Roger (AR), Audit Wales Senior Performance Auditor, presented the Local Cancer Services Review, which examined how the Health Board planned, prevented and managed cancer services, including early detection and performance oversight.

AR reported that performance against the 62-day target remained below the required standard, with 63.2% of patients starting treatment within 62 days in March 2026 against a target of 75%. The review found that there was no single costed plan for delivering the cancer strategy and meeting future demand, and that forecasting, capacity modelling, patient-experience information and outcomes data were not being used fully.

Governance arrangements also required strengthening through the appointment of a Clinical Cancer Lead and re-establishment of the Cancer Board. Six recommendations were made and accepted by management.

CW accepted the findings and highlighted the weaknesses identified in service planning, patient experience, prevention and outcomes. She advised that recruitment to the Clinical Cancer Lead post was underway and that a revised governance structure was being developed. Once appointed, the Clinical Cancer Lead would support the establishment of a Cancer Board overseeing pathways and performance; clinical safety, quality and innovation; prevention, screening and earlier diagnosis; and patient experience, personalised care and outcomes.

She reported that performance was holding at approximately 63% despite increased demand and that an improvement trajectory was in place to achieve 75% by the end of the financial year.

CP supported the recommendation for a longer-term costed improvement plan but requested that a short-term costed plan also be developed to provide momentum to implementation.

CW acknowledged the need for both short and longer-term plans and advised that detailed demand-and-capacity analysis was underway to support their development.
Digital Transformation Review

Digital Transformation Review:
Jeff Brown (JB), from Audit Wales, presented the Digital Transformation Review, which formed part of a national thematic review across NHS Wales and considered whether the Health Board's approach to digital transformation supported service improvement.

He reported that the Health Board had a reasonably clear strategic approach and oversight arrangements. However, Clinical Board responsibilities for digital transformation were not clearly defined, controls relating to digital infrastructure, cyber

	security and artificial intelligence were not fully effective, and the organisation did not have a comprehensive understanding of workforce digital skills. The review also identified a need for greater assurance regarding the effectiveness of digital inclusion arrangements and highlighted the Health Board's reliance on the successful delivery of the Digital Foundations Programme. Eight recommendations had been agreed with management. Angela Parratt (AP), Assistant Director of Digital and Health Intelligence, welcomed the review and confirmed that work was underway across the areas identified. This included joint work with People and Culture on digital literacy and the development of a Board Development Session, led by David Thomas (Director of Digital & Health Intelligence), to improve members' understanding of digital transformation and the Health Board's plans. AP advised that a contingency approach was being developed in response to uncertainty surrounding the Digital Foundations Programme. However, significant investment would be limited without the programme, requiring future digital developments to be prioritised according to their clinical and operational impact. DE emphasised that digital transformation was fundamental to improving data quality, clinical coding, patient information, organisational performance and patient outcomes. He expressed support for the Digital Foundations business case as a key enabler of future improvement. **The Committee resolved that:** a) The Audit Wales Updates were noted.	
A&A 26/09/2.7	**Car Parking Procurement – Lessons Learnt** The Car Parking Procurement Lessons Learnt Report was received and presented by Helen James (HJ), Head of Procurement. She advised that the procurement had been undertaken following the introduction of a new legislative regime. Under the previous arrangements, applications to lift a suspension of a procurement process had generally been accepted by the courts. However, the application relating to the car parking contract had been unsuccessful, with public-interest considerations appearing to have been given greater weight. HJ confirmed that legal and counsel advice had been obtained during the process. Following the outcome, the Health Board had reviewed its approach and identified lessons to strengthen future procurement activity. These included greater focus on internal processes, senior-level consideration of the prospects of future applications to lift procurement suspensions, and improvements to tender documentation. The report set out the steps being taken to reduce the risk of a similar situation arising in future. **The Committee resolved that:** A) The content of the report was noted.	
A&A 26/09/2.6	**Post Payment Verification – End of Year Report 2025-26** The Post Payment Verification (PPV) End of Year Report 2025/26 was received and presented by Amanda Legge (AL), All Wales Post Payment Verification Manager supported by Sara Jeremiah (SJ), PPV Location Manager for Cardiff and Vale UHB.	

	AL confirmed that all planned General Medical Services routine visits for 2025/26 had been completed. The new three-year cycle for 2026/27 had commenced, with outstanding revisits being incorporated into routine visits where appropriate. All outstanding General Ophthalmic Services visits had also been completed, and the PPV programme remained on schedule for the current financial year. AL advised that PPV activity continued to be delivered through established arrangements, including regular engagement with Health Boards, working groups and Counter Fraud colleagues. Reports arising from contractor visits were shared with the relevant Health Board and local Counter Fraud teams, with concerns escalated at an early stage to support proactive risk management. It was emphasised that PPV was not solely focused on financial recovery but also supported organisational learning, prevention and service improvement. Training and support were provided to contractors where required, and recurring issues were analysed to identify root causes and reduce the likelihood of repeat claiming errors. AL also advised that Power BI dashboards were being developed to improve the presentation and oversight of PPV information for Audit Committees. The proposed reporting format would be shared for feedback before submission. **The Committee resolved that:** A) The contents of the report were noted	
A&A 26/09/2.5	**Procurement Compliance Report** The Procurement Compliance Report was received and presented by Gareth Stallard (GS), Deputy Head of Operational Procurement. He reported that there had been 42 instances of non-compliance year to date, including 27 during the latest reporting period. This represented 11 fewer instances than during the equivalent period in the previous financial year. He attributed the improvement partly to increased training and engagement with Clinical Boards and other Health Board stakeholders. One Single Tender Action had been recorded during the latest period, compared with 22 across the previous financial year. GS advised that earlier engagement with Clinical Boards was helping ensure that requirements above £5,000 were referred to Procurement before commitments were made, reducing retrospective expenditure and the need for Single Tender Actions. DE welcomed the reduction in the number of cases and asked whether there had been a corresponding reduction in their financial value. GS confirmed that there had been no Single Tender Actions above the national advertising threshold during the previous year. Although some higher-value non-compliance had occurred because of urgent or emergency requirements, most instances were of relatively low value and only slightly exceeded the £5,000 threshold. He noted that inflationary pressures had also caused some expenditure that had historically fallen below the threshold to exceed it. **GS offered to include further year-on-year analysis of the value of non-compliant activity, and DE requested that this be incorporated into future reports.**	

	The Committee resolved that: a) The contents of the report were noted	
A&A 26/9/2.8	**Risk Management** The Risk Management Report was received and presented by MP He advised that the report brought together the live actions and recommendations concerning risk management arising from the Internal Audit review, the Audit Wales Structured Assessment, the Health Board's escalation arrangements and the latest correspondence from Welsh Government. This provided a consolidated audit trail of the improvement work undertaken and the outstanding requirements. MP also presented a revised Corporate Risk Register. He explained that the previous approach of reporting all organisational risks scoring 20 or above had become unmanageable following the consolidation of approximately 70 to 80 separate risk registers into the AMAT system. The single organisational register now contained more than 1,400 risks, including over 100 scored at 20 or above, many of which related to specific Clinical Boards or directorates rather than the organisation as a whole. The consolidated data had therefore been analysed to identify common themes by cause and effect. This had supported the development of 13 corporate risks affecting the organisation as a whole, which had subsequently been refined through discussions with the Executive Team. MP advised that further work was required to strengthen the description of some controls, but the revised register provided a more credible and focused representation of the Health Board's principal corporate risks. **The revised Corporate Risk Register would be presented to the Board later in September 2026 for approval**, recognising that ownership of the register would sit at Board level. DE welcomed the revised approach and considered that it represented a considerable improvement. **The Committee resolved that:** a) The contents of the report were noted.	
A&A 26/9/4.1	**Counter Fraud** The Counter Fraud Progress Update was received. **The Committee resolved that:** a) The Counter Fraud Progress Updates were noted.	
A&A 26/09/6	**Any Other Business** No Other Business was discussed.	
A&A 26/09/7.1	**Items to be deferred to Board / Committee** • Five Steps of Safer Surgery Audit findings and outstanding actions to be monitored through the Quality Committee. • Health Inequalities (Ethnicity Data) Audit to receive further consideration through the Quality Committee. • Revised Corporate Risk Register endorsed for submission to Board for approval.	

A&A 26/09/7.2	**Date and time of next committee meeting** Tuesday 3 November 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 - Five Steps of Safer Surgery	A&A 26/09/2.1	A specific reference to the actions taken as a result of the Five Steps of Safer Surgery audit to form part of the assurance element of the AAA reporting into Quality Committee.	David Fluck	Clare Wade, Jesse Ayertey	01/09/2026	03/11/2026	**COMPLETE**	Was received by the Quality Committee on 29.09.2026 - Clinical Board Highlight Report for Surgery	Was included in the Clinical Board Highlight Report for Surgery
AUDIT & ASSURANCE	Internal Audit Progress Report - Flexible Working Audit	A&A 26/09/2.1	Provide an update to the Committee on the work of the Flexible Working Task and Finish Group and progress against the audit actions - Clive Curtis specifically requested an update from the Task and Finish Group and Claire Whiles agreed to bring this back.	Rachel Gidman	Catherine Wood, Claire Whiles	01/09/2026	03/11/2026	**IN PROGRESS**	Update to be provided via the Action Log discussion on 03.11.2026. Any reading can be circulated to the Committee via email.	Next Audit & Assurance Committee meeting (November 3 2026).
AUDIT & ASSURANCE	Procurement Compliance Report	A&A 26/09/2.5	To include year-on-year analysis of the financial value of non-compliant procurement activity within future Procurement Compliance Reports - David Edwards specifically requested additional information on value, not just volumes, and Gareth Stallard agreed to review this.	Catherine Phillips	Claire Salisbury, Gareth Stallard	01/09/2026	03/11/2026	**ON FORWARD PLAN**	Is included in the procurement compliance report for November 3rd Meeting	

Report Title: *(needs to match agenda)*	Internal Audit Progress Report		Agenda Item No:		2.1
Meeting:	Audit & Assurance	Public	X	Meeting Date:	03/11/26
		Private			
Lead Executive Title:	Director of Corporate Governance				
Report Author/s Title:	Head of Internal Audit				

Report Focus Summary – **AAA Framework:**
*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

The audit of Audiology Referral and Waiting List Management has been completed with a **Limited** assurance rating.
A number of significant control weaknesses reduce assurance over the effectiveness and sustainability of the control framework. The issues identified increase the risk of inaccurate performance reporting, delays in patient care, reduced oversight of long-waiting and follow-up patients, and inconsistent management of referral and waiting list pathways.
We identified 4 **high-priority** issues relating to:

- Referral, Triage and Pathway Management Arrangements;
- Referral Pathway Documentation and System Guidance;
- Quality Improvement Action Plan; and
- Routine reporting and oversight of follow-up activity.

High-priority issues have also been identified within the following audit reports that provide Reasonable assurance overall:

- Automation / AI:
  - Insufficient resource to coordinate and improve the use of AI and Automation;
  - Lack of guidance for the use of Automation; and
  - No coordinated change control process.
- Infection Prevention & Control:
  - Absence of an approved Annual IP&C Programme
  - Timeliness, completion and monitoring of IPC incident reporting
- CD&T CB Governance and Financial Arrangements:
  - Savings plans not identified to achieve the full savings target.

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required *(please select only one)*
To confirm the action Members are being asked to take considering the AAA Framework

Assurance	X	**Approval**		**Information/Noting**	

Recommendations
Recommendations should be clear, actionable, and aligned to the AAA summary above.

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed adjustments to the 2026/27 plan.

Governance Route ***(please list all other Committee/Groups this report has been to)***	
Where *it's been:*	
When *it went:*	
What *decision was made:*	

Main Report

Background & Current Situation

The 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 the 2026/27 Annual Plan which was formally approved by the Audit Committee at its May 26 meeting.

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

The following reports have been finalised since the September 26 meeting:

- Development of the Clinical Services Plan (Substantial Assurance)
- Automation / AI (Reasonable Assurance)
- Infection Prevention & Control (Reasonable Assurance)
- CD&T CB Governance and Financial Arrangements (Reasonable Assurance)
- Audiology Referral & Waiting List Management (Limited Assurance)

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

The progress report also includes details of the following proposed adjustments to the 2026/27 plan:

- Removal of the Strategic Planning Infrastructure audit.
- Deferral of the Regulatory & Legislative Compliance audit.
- Removal of the Tracking of Improvements Following Reviews audit.

The reasons for the changes are noted within the progress report and all have been agreed by the relevant Executive leads.

Appendices:

(List any appendices that will accompany this report).

Strategic Alignment – Shaping Our Future Wellbeing:

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

Impact Assessment

Risk: Yes

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

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

Financial: Yes
The progress report includes the outcome from audits that provide assurance around controls and processes relating to Finance.
Workforce: No
Not applicable.
Legal: No
Not applicable.
Reputational: No
Not applicable.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Not applicable.
Equality & Health: No
Not applicable.
Decarbonisation: No
Not applicable.
Welsh Language: No
Not applicable.

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee November 2026

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

1.Introduction *3*
2.Assignments with Delayed Delivery *3*
3.Outcomes from Completed Audit Reviews *3*
4.Delivery of the 2026/27 Internal Audit Plan *4*
5.Changes to the 2026/27 Internal Audit Plan *4*
6.Final Report Summaries *5*

Appendix A Assignment Status Schedule
Appendix B Report Response Times
Appendix C Key Performance Indicators
Appendix D 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 2026/27 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 2026/27 was agreed by the Audit & Assurance Committee in May 2026 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

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

Audit	Current Position	Draft Rating	Reason
Cyber Security Follow-up	Draft Report	N/A	Delay in receiving management actions and sign-off of the draft report.
Follow-up: Interventions Not Normally Undertaken	Fieldwork		Delay in meeting lead contacts and progressing fieldwork due to IA resources.
Medicine CB Governance and Financial Arrangements	Fieldwork		Delays in getting meetings with lead contacts and receiving information.

3. Outcomes from Completed Audit Reviews

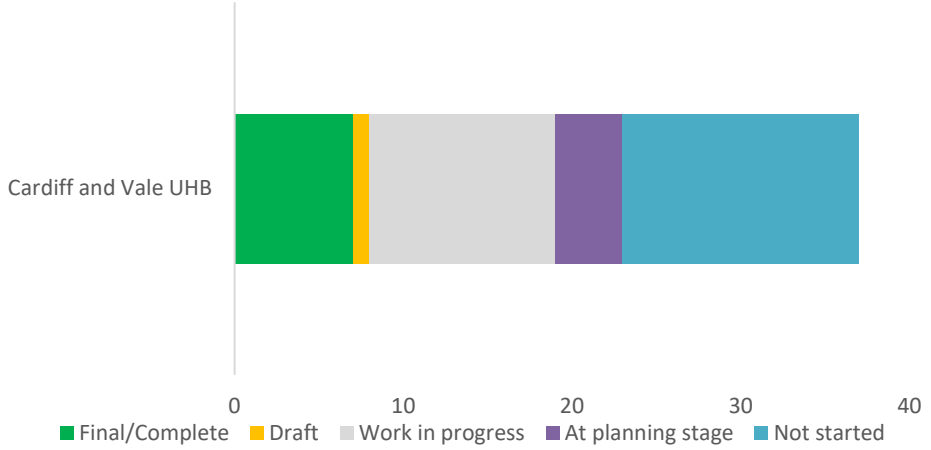
Five assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Development of the Clinical Services Plan	Substantial	
Automation / AI	Reasonable	
Infection Prevention & Control		
CD&T CB Governance and Financial Arrangements		
Audiology Referral & Waiting List Management	Limited	

4. Delivery of the 2026/27 Internal Audit Plan

There is a total of 37 reviews within the 2026/27 Internal Audit Plan, (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that seven audits from the 2026/27 plan have been finalised so far this year and one other has reached the draft report stage.

In addition, there are 11 audits that are currently work in progress with a further four at the planning stage.

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

Appendix A also includes details of the audit from the 2025/26 plan that was not sufficiently progressed to be included within the Head of Internal Audit Opinion for 2025/26. The audit has now been finalised and the outcome will feed into the 2026/27 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 26/27 Internal Audit Plan

The following audits have been identified for removal from the 2026/27 plan:

- Strategic Planning Infrastructure - Proposed for removal from the 26/27 plan due to the volume of audit work already being undertaken within the Planning function. Supported by the Executive Director of Planning.
- Regulatory & Legislative Compliance - Proposed for deferral to the 27/28 plan due to ongoing work to develop processes. Supported by the Director of Corporate Governance.
- Tracking of Improvements Following Reviews - Proposed for removal from the 26/27 plan as it had been agreed with the previous CEO but is no longer seen as a priority area for review. Supported by the Director of Corporate Governance.

6. Final Report Summaries

6.1 Development of the Clinical Services Plan



Substantial Assurance

Purpose

Our audit of the Development of the Clinical Services Plan was completed as part of our 2026/27 Internal Audit work for Cardiff and Vale University Health Board (the 'Health Board').

Overview

The Health Board has developed the Clinical Services Plan (CSP) to respond to strategic challenges facing the organisation and the wider NHS in Wales, including rising demand, workforce pressures, financial constraint, estate fragility and persistent health inequalities.

The CSP has been developed to sit alongside and directly inform other strategic plans including, People and Culture, Estates and Digital, as well as the developing organisational Redesign Programme.

The CSP has been developed through a clinically led, evidence based and iterative planning approach, including:

- Executive level ownership and Clinical leadership and involvement;
- Co-production with people who use the services informing the engagement approach and principles;
- Engagement to ensure they hear what matters most to the communities that they serve, colleagues and partners;
- Co design workshops to develop a model of care and priorities together with patients, colleagues, partners and policy makers;
- Use of population health intelligence, horizon scanning, baseline assessments, and demand and capacity analysis and financial trajectories; and
- Alignment with national policy and regional strategies.

We have concluded **substantial** assurance on this area. The Health Board had a robust and well-governed framework for developing the Clinical Services Plan, supported by effective stakeholder engagement, appropriate governance arrangements, comprehensive risk management, and clear evidence that feedback from stakeholders informed the final plan that was formally launched in June 2026. We have identified one matter that requires management attention:

- A formal review of the development of the CSP should be undertaken to identify any lessons learned. Whilst a session had been scheduled by the Oversight Group at the time of our fieldwork; it was subsequently postponed and has not yet taken place. However, a number of initial lessons learned have already been identified.

Scope & Assurance Summary

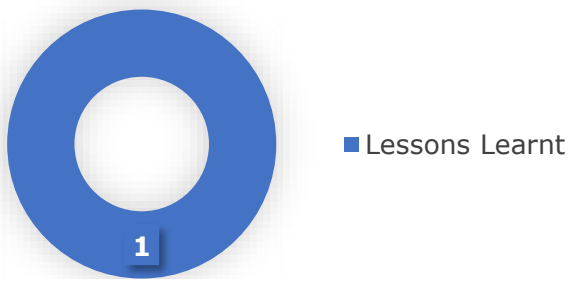
Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There is a Health Board framework which sets out the approach in ensuring the application of good and effective public engagement practice.	-	**Substantial**
2	A stakeholder engagement programme plan is in place which sets out the approach for how the engagement is to be conducted and a timetable for the development of the Clinical Services Plan.	-	**Substantial**
3	Key stakeholders have been adequately identified and continuously involved in the engagement process of developing the Clinical Services Plan.	-	**Substantial**
4	Results / outcomes of public engagements undertaken are assessed and incorporated to inform the development of the Clinical Services Plan.	-	**Substantial**
5	There are appropriate governance arrangements, which provide effective oversight of the stakeholder process and the development of the Clinical Services Plan.	-	**Substantial**
6	Risks in relation to stakeholder engagement are appropriately considered and monitored.	-	**Substantial**
7	Lessons learnt during the development of the Clinical Services Plan are identified and form part of the continual improvement of the planning cycle.	1	**Reasonable**

Management Actions

0 High Priority

1 Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

6.2 Automation / AI



Reasonable Assurance

Purpose

To review how the Health Board is developing and delivering a governance structure around the use of AI and automation.

Overview

We have concluded **reasonable** assurance on this area. The Health Board has a stated intent to increase the use of automation and AI, and there are relevant targeted milestones within the Annual Plan. Whilst there is no 3rd party automation provider, there is increasing use of Power Automate within the organisation. There are a number of AI products in use, and the governance arrangements over AI have been improved recently.

The matters requiring management attention include:

- There is minimal resource within Digital to coordinate and improve the uptake and use of AI and Automation, in particular 365 products, and there is no capacity to develop and mobilise structured plans to increase use, though use is growing amongst the user base as expected with a lo-code solution. As such the Health Board will struggle to gain the benefits of AI and automation and there is an increased risk of developing silos should Clinical Boards move forwards with the power platform without coordination and monitoring.
- There is currently no actively maintained register of AI in use across the Health Board which includes the benefits of use.
- The guidance on the use of AI misses some key aspects that would be expected within a fully complete good practice guide.
- There is currently no guidance in place for the use of automation (Microsoft Power Automate). The use of automation can introduce risks, including both data leakage and siloing of data, as such without formal guidance in place the health board has not set out guidelines for approved use, development standards, data handling, change management and monitoring and ownership.
- The assessment and approval process for AI use does not formally consider and document the accuracy of the model against metrics, understanding of the training of the model or associated benefits.
- The assessment and prioritisation mechanisms for potential automations are, in most cases, informal, undocumented and reliant on professional judgement, with no true assessment of benefits.
- The design of automations is not fully, consistently recorded, neither is the testing, outcomes of that and agreement of operation by the user.
- Automated workflows are, in many cases currently operating under the developers account and not within a dedicated service account.
- There is no coordinated process to ensure that changes to the operating environment are fully assessed for the impact on automated workflows and communicated to relevant staff. This is exacerbated by the lack of design documents for automations and a lack of change control over the automations.

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:

- The Health Board should consider appointing a Digital Clinical Safety officer and complying with DCB0160.
- Guidance for Power Automate should include the assessment and prioritisation mechanisms for potential automations.

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 use of evolving technology is included within organisation plans, with appropriate resources available to develop their use.	1	**Reasonable**
2	An appropriate governance structure with controls and guidance is in place for the use of AI and automation which protects information, accounts used for AI and RPA and ensures that models are accurate, free from bias and protect information.	2, 3, 4	**Limited**
3	An appropriate process is in place to control the use of AI and the creation of robots and the resource use, with an assessment process to ensure AI use is appropriate, only suitable processes are automated and benefits are defined and realised.	5	**Reasonable**
4	Appropriate processes are in place to fully document development of AI models, the design of automated process and test the final product and monitor the operation of robots to ensure they operate as expected.	6, 7	**Reasonable**
5	An appropriate process is in place to ensure that changes to the environment in which automated processes operate are assessed for the impact, changes to automated processes are recorded and appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the technology.	8	**Limited**

Management Actions

3 High Priority Priority

5 Medium

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

6.3 Infection Prevention & Control



Reasonable Assurance

Purpose

Our audit review of Infection Prevention and Control was completed in line with the 2026/27 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board'). The purpose was to review the controls in place for the management of key systems and risk areas in relation to infection prevention and control.

Infection Prevention and Control (IPC) is fundamental in ensuring the provision of a safe environment for staff and service users.

Healthcare Associated Infection (HCAI) refers to an infection that occurs because of contact with the healthcare system. A consistent approach and effective leadership within the Health Board is required to prevent HCAI within Health Board services.

The Health Board's central IPC Team provides advice and support to all Health Board services, particularly clinical and front facing staff. IPC is however the responsibility of all Health Board staff, with Clinical Boards responsible for ensuring effective IPC management within their operational services.

Infection Control is reported as part of the Integrated Performance Report detailing the number of infection control cases within the Health Board.[1]

A recent Independent Assessment of the Health Board highlighted that 'staff had been found to be poorly compliant with Infection Prevention and Control Standards.' However, the scope of our IPC audit was focussing on the governance and processes in place across the Health Board. The review did not include an assessment of IPC practices at ward level.

Overview

We have concluded **reasonable assurance** on this area. Whilst improvements are required to strengthen the IPC control framework, we recognise that governance structures, committee oversight and performance reporting are generally operating effectively.

The matters requiring management attention include:

- IPC policies and procedures were not consistently available, up to date, or approved.
- There was no approved annual IPC Programme to direct and monitor IPC activities.
- Gaps were identified in the timeliness, completion, and monitoring of infection control incident reporting and investigations.
- IPC Group Terms of Reference (ToR) were in draft form and did not fully reflect current governance arrangements and accountabilities.
- IPC Group attendance, quorum compliance, and action-tracking arrangements require strengthening to support effective oversight and accountability.

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

[1] RFA - CAV-FTS-61017 - Provision of Travel and Transport Bookings (1).xlsx page 182

Scope & Assurance Summary

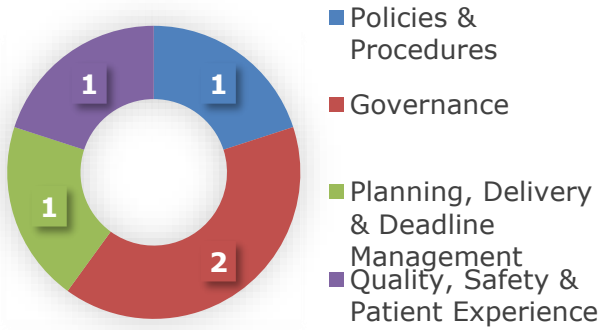
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The Health Board has appropriate, up to date infection prevention and control policies and procedures in place which provide clear direction and align with Welsh Government requirements and relevant legislation	1	**Reasonable**
2	An appropriate infection control framework and / or plan is produced and effectively communicated and implemented across the Health Board	2	**Limited**
3	Robust incident reporting and monitoring processes are in place across the Health Board to allow for accurate and timely identification and recording of all infection control related incidents to ensure appropriate actions are taken and lessons are learned	3	**Limited**
4	There is an Infection, Prevention and Control (IPC) group in place which is supported by a clearly defined and up to date Terms of Reference (ToR) which includes confirmation of appropriate and relevant membership	4	**Reasonable**
5	The IPC Group operates in accordance with its ToR, and members attend meetings regularly	5	**Reasonable**
6	There is regular reporting on IPC performance, and reports are submitted to appropriate management and Board level Groups for information and action		**Substantial**

Management Actions

2 High-Priority

3 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

6.4 CD&T CB Governance and Financial Arrangements



Reasonable Assurance

Purpose

Our review of the processes in relation to Clinical Diagnostics and Therapeutics (CD&T) Clinical Board Governance and Financial Arrangements was completed in line with the 2026/27 Internal Audit Plan for Cardiff & Vale University Health Board ('the Health Board').

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

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

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

CD&T Clinical Board has seven directorates covering Pharmacy and Medicines Management, Radiology and Medical Physics / Clinical Engineering, Therapeutics and Toxicology, Therapies, Medical Illustration, Outpatients / Patient Administration and Laboratory Medicine. These provide a wide range of diagnostic and therapeutic procedures on a local, national and UK-wide basis.

Overview

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

- There was an absence of a Terms of Reference for one Directorate governance group and some ToR required updating or finalising.
- Several meetings did not achieve the required quorum requirements set out in the ToR, and there was limited assurance that key members consistently attended meetings as required. In addition, meeting minutes were not always available for all meetings held, reducing the ability to demonstrate effective oversight, challenge and accountability.
- The Clinical Board has been unable to identify and deliver sufficient savings to meet the target set by the Health Board.

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

Scope & Assurance Summary

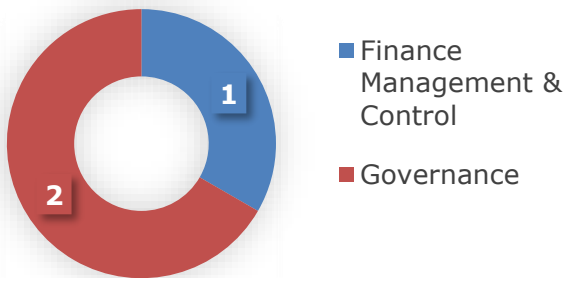
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	An appropriate governance structure is in place within the Clinical Board including all required groups, aligned to the Health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

Management Actions

1 High Priority

2 Medium Priority

Themes



Risk Types

Financial Loss

Quality or Safety Issues

6.5 Audiology Referral & Waiting List Management



Limited Assurance

Purpose

The review of Audiology Referral and Waiting List Management was completed in line with the 2026/27 Internal Audit Plan for Cardiff and Vale University Health Board ('Health Board'). The overall scope was to review the processes within the Adult and Children's Audiology services for the management of referrals, waiting lists and follow-up appointments.

Audiology is the discipline concerned with assessment and treatment of hearing and balance disorders and the specialities include hearing assessment, hearing aid fitting and rehabilitation, hearing therapy, vestibular/ balance assessment, paediatric hearing aid services, patient and adult cochlear implants and bone anchored hearing aids.

New patients to Audiology require a referral by a Doctor or an Allied Health Professional. Existing patients are encouraged to have a reassessment of their hearing, three years after the initial fitting of their hearing aid. Welsh Government have produced a 'Future Approach for Audiology Services' which is a reform to shift NHS hearing care out of hospitals and into local communities.

The Executive Lead for the audit is the Executive Director of Allied Health Professionals, Health Scientists and Community Services Development.

Overview

We have concluded **limited** assurance on this area. Although core Audiology referral, waiting list and follow-up processes are operating in practice and most patients sampled were appropriately prioritised and managed, a number of significant control weaknesses reduce assurance over the effectiveness and sustainability of the control framework. The issues identified through our audit increase the risk of inaccurate performance reporting, delays in patient care, reduced oversight of long-waiting and follow-up patients, and inconsistent management of referral and waiting list pathways.

The significant matters requiring management attention include:

- Key referral and waiting list Standard Operating Procedures (SOPs) are in place but remain incomplete or not fully approved, limiting assurance that referral triage, RTT management and pathway arrangements are consistently governed.
- AuditBase recording requirements, pathway responsibilities and staff guidance are not yet fully documented, increasing the risk of inconsistent data entry, pathway management and RTT reporting.
- Referral pathway administration controls require strengthening, as issues were identified with priority recording, pathway ownership, RTT clock management and governance for ENT-related referrals.
- Most high-risk and long-waiting patients sampled were appropriately prioritised, but there were gaps in waiting list visibility, paediatric criteria, deterioration monitoring and data quality which reduce assurance over patient oversight.
- Incident and complaint themes indicate weaknesses in identifying patients at risk of harm, recording alerts and escalating cases where patients are delayed or potentially lost to follow-up.

- Waiting list reporting and validation processes rely on bespoke reports and specialist knowledge but are not fully documented within an approved procedure, creating resilience and consistency risks.
- Governance oversight of waiting list and follow-up performance is not sufficiently evidenced, with limited audit trail showing challenge, agreed actions, escalation and tracking to completion.
- The Quality Improvement Action Plan contains a significant proportion of unresolved red and amber actions, indicating that known service risks and improvement actions are not being progressed in a timely or consistently evidenced way.
- Patient communication arrangements are operationally embedded but rely heavily on manual letters and staff knowledge, with no formal guidance setting out responsibilities, timescales or cover arrangements.
- The onward referral policy requires review to better define scope, referral criteria, evidence requirements, feedback arrangements and compliance monitoring.
- Historic waiting lists, outcome statuses and pathway migration remain unresolved, meaning follow-up tracking continues to rely on manual review and administrative accuracy until the new referral model is fully embedded.
- Follow-up performance reporting is not yet comprehensive across all patient cohorts, limiting management oversight of due reviews, overdue follow-ups, delays and exception reporting.

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

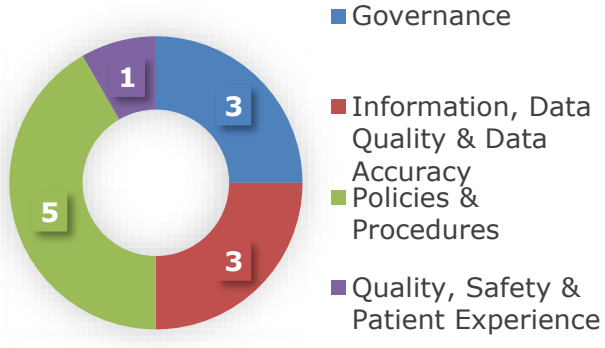
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Audiology referrals are appropriately recorded, triaged, and processed in a timely manner	1,2,3	**Limited**
2	Effective arrangements are in place for prioritising patients based on their current health care needs (e.g. regular assessments and reprioritisation)	4,5	**Reasonable**
3	Effective arrangements are in place to monitor waiting lists and action plans are produced to reduce the waiting times for patients, with appropriate reporting to the Health Board	6,7,8	**Limited**
4	Adequate arrangements are in place to communicate with patients waiting for audiology service, including the offer of additional support if required	9,10	**Reasonable**
5	Audiology Services have appropriate and clear plans in place to ensure that patient follow-ups are undertaken within recommended timeframes and actions are taken if there are delays	11,12	**Limited**

Management Actions

4	8
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2025/26 Plan							
Follow-ups not booked	30	COO	1		Final Report	Limited	September
2026/27 Plan							
Speaking Up Safely	02	Corporate Governance	1		Final Report	Reasonable	September
ALAS Equipment Purchasing and Stock Management	31	Therapies and Health Sciences	1		Final Report	Reasonable	September
AI - Use of Robotics and Automation	28	Digital & Health Intelligence	1/2		Final Report	Reasonable	November
Audiology Referral and Waiting List Management	32	Therapies and Health Sciences	1		Final Report	Limited	November
Infection Prevention and Control	18	Nursing	~~3~~	2	Final Report	Reasonable	November
CD&T CB Governance and Financial Arrangements	21	Chief Operating Officer	2		Final Report	Reasonable	November
Development of the Clinical Services Plan	35	Strategy, Planning and Partnerships	1/2		Final Report	Substantial	November
Cyber Security Follow-up	27	Digital & Health Intelligence	~~TBC~~	2	Draft Report	N/A	February
Follow-up: Interventions Not Normally Undertaken	15	Medical	~~TBC~~	2	Fieldwork		February
Medicine CB Governance and Financial Arrangements	22	Chief Operating Officer	~~3~~	2	Fieldwork		February
CB Adherence to the Managing Attendance at Work Policy Follow up	08	People & Culture	2		Fieldwork		February
Budget Setting	05	Finance	2		Fieldwork		February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Escalation Status Governance / Actions	04	Strategy, Planning and Partnerships / Finance	2/3		Fieldwork		February
Clinical Audit	14	Medical	~~2/3~~	3	Fieldwork		February
Telecoms	29	Digital & Health Intelligence	2/3		Fieldwork		February
Endoscopy	24	Corporate Governance	~~1/2~~	3	Fieldwork		February
Nationally Reportable Incidents (NRIs)	19	Nursing	~~2/3~~		Planning		February
Digital Systems Uptake and Utilisation	30	Digital & Health Intelligence	~~3~~		Fieldwork		February
Staff Rostering	10	People & Culture / Relevant Staff Group Executives	~~1/2~~	3	Fieldwork		February
Radiology Staff Rotas	23	Chief Operating Officer / Therapies and Health Sciences	~~1~~	3			February
Flexible Working Arrangements for Compressed and Variable Hours Follow-up	40	COO / People & Culture	~~TBC~~	3	Draft brief issued		February
Grip & Control Arrangements – Self Assessment Review	41	Finance	~~3~~		Final brief issued		May
Workforce Planning	11	People & Culture	3				May
People & Culture Strategic Development	12	People & Culture	3				May
Planned Care	25	Chief Operating Officer	~~2/3~~	3			May

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Risk Management and Board Assurance Framework	01	Corporate Governance	4				May
Staff Overpayments Follow up	09	People & Culture / Finance	~~TBC~~	4			May
Medical staff deployment Assurance Audit	13	Medical	3/4				May
Quality Management System	16	Nursing / Medical	3/4				May
Primary Care Services	26	Chief Operating Officer	3/4				May
Demand & Capacity Modelling	34	Strategy, Planning and Partnerships	1/2	3/4			May
Reducing Health Inequalities Follow-up	42	Public health	4				May
Neurodevelopment Services for Adults Follow-up	43	COO	4				May
Estates Assurance	07	Finance	TBC				TBC
Approved Integrated Audit & Assurance Plan Assignments:							
Modernisation of Passenger Lifts: University Hospital Wales	37	Finance	2		Fieldwork		February
Pentyrch/Rhydlafar Branch Surgery	38	Finance	3		Final brief issued		February
Park View Health Centre	39	Finance	TBC				TBC
Reviews removed from the plan							
Clinical Safety Groups	17	Nursing	Proposed for deferral to the 27/28 plan due to ongoing work to restructure the groups. Supported by the Executive Director of Nursing. Agreed by September 26 AC.				

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Charitable Funds	06	Finance	Proposed for deferral to the 27/28 plan due to recent staff changes and ongoing work to implement the new strategy. Supported by the Executive Director of Finance. Agreed by September 26 AC.				
Diabetes 8 Care Processes	20	Public Health	Proposed for removal from the 26/27 plan due to overlap with the scope of the Audit Wales Diabetes Management review. Supported by the Executive Director of Public Health. Agreed by September 26 AC.				
Strategic planning Infrastructure	36	Strategy, Planning and Partnerships	Proposed for removal from the 26/27 plan due to volume of audit work already being undertaken within the Planning function. Supported by the Executive Director of Planning. To be agreed by November ARAC.				
Regulatory and Legislative Compliance	03	Corporate Governance	Proposed for deferral to the 27/28 plan due to ongoing work to develop processes. Supported by the Director of Corporate Governance. To be agreed by November ARAC.				
Tracking of improvements following reviews	33	Chief Executive	Proposed for removal from the 26/27 plan as it was agreed with the previous CEO but no longer seen as a priority area for review. Supported by the Director of Corporate Governance. To be agreed by November ARAC.				

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Speaking Up Safely	Reasonable	Final	03/07/26	24/07/26	23/07/26	23/07/26	G
ALAS Equipment Purchasing and Stock Management	Reasonable	Final	27/07/26	17/08/26	13/08/26	13/08/26	G
Follow-ups Not Booked	Limited	Final	06/07/26	27/07/26	14/08/26	14/08/26	R
AI - Use of Robotics and Automation	Reasonable	Final	13/08/26	04/09/26	17/09/26	24/09/26	R
Audiology Referral and Waiting List Management	Limited	Final	25/08/26	16/09/26	17/09/26	17/09/26	G
Infection Prevention & Control	Reasonable	Final	03/09/26	24/09/26	08/10/26	09/10/26	R
CD&T CB Governance and Financial Arrangements	Reasonable	Final	16/09/26	07/10/26	12/10/26	12/10/26	R
Development of the Clinical Services Plan	Substantial	Final	29/09/26	20/10/26	20/10/26	20/10/26	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2026/27	G	May 2026	By 30 June	Not agreed	Draft plan	Final plan
Audit reports to agreed Audit Committee	A	64% 7 from 11	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 9 from 9	95%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	50% 4 from 8	85%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 8 from 8	95%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

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



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Archwilio Cymru
Audit Wales

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

Date issued: October 2026



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Introduction

This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in 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 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:** Fieldwork ongoing
- **Expected committee date:** January 2027 (Board of Trustees)

Audit of 2026-27 Health Board Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2026-27 Health Board Annual Report and Accounts
- **Status:** Planning to commence winter 2026
- **Expected committee date:** June 2027

Performance audit update

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

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This work examined 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:** Clearance - draft report issued in August 2026
- **Expected committee date:** February 2027

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** Our 2026 structured assessment approach has been revised to place greater emphasis on effectiveness and impact. Our work, therefore, will focus on the Health Board's 2025-26 Annual Plan, considering both what has been planned and delivered, and the impact these actions are having on organisational finances, performance and outcomes. As part of our fieldwork, we will also gather high-level intelligence on hosted bodies and joint committees to inform our broader understanding of these arrangements.
- **Status:** Fieldwork underway
- **Expected committee date:** February 2027

Diabetes management review

- **Executive Lead:** Executive Director of Public Health
- **Focus of the work:** This review will examine how well the Health Board cares for people living with Type 1 and Type 2 diabetes, to help stop their condition getting worse, reduce avoidable complications, and improve outcomes.
- **Status:** Audit brief will be issued in November 2026
- **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:** May 2027

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.

Diabetes in Wales – is the NHS ready for the future?	October 2026
Finding the right match: Latest results for Wales from the National Fraud Initiative	October 2026
Young people, opportunity and mental health in Wales: Understanding what's behind the rising numbers outside of Education, Employment and Training	October 2026
NHS digital: delivery not matching ambition	September 2026

Since the last committee update, Audit Wales has published its Welsh Language Report 2025-26.

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.

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We welcome correspondence and telephone calls in Welsh and English.

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

Report Title:	**Risk Management**		Agenda Item No:		2.3
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	03.11.2026
		Private			
Lead Executive Title:	Director of Corporate Governance				
Report Author/s Title:	Corporate Archivist & Records Management Manager				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

- There is now a distinction between the Corporate Risk Register (13 whole organisation risks that were approved at Board in Sep 26) and the Organisational Risk Register (the ~1,500 risks from every corner of the organisation).
- This report shows how they align.
- The work through the Organisation Risk Management Group (ORMG) to moderate risks has seen extreme risks (20+) reduce from 200 to 153.
- The biggest contingent of 20+ risks by CB/Directorate or theme is in Estates.
- All 20+ risks are set out in the appendix.
- Work continues in Committees, CB Reviews and the ORMG to drive the actions in response to these risks.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Committee Response Required					
Assurance	**X**	**Approval**		**Information/Noting**	

Recommendations

The Committee is requested to:

• **NOTE** the journey from the former threshold-based Corporate Risk Register to the Board-approved thematic Corporate Risk Register, underpinned by the Organisational Risk Register.
• **NOTE** the current profile of 153 extreme risks scoring 20 to 25 and the areas of concentration, age and response set out in this report.
• **RECEIVE ASSURANCE** that detailed operational risk visibility is being retained through the Organisational Risk Register and associated Clinical Board, Directorate, Committee and ORMG review arrangements.
• **ENDORSE** the continued use of the Organisational Risk Register, including an agreed and regularly reviewed mapping to the 13 thematic Corporate Risks, to inform Board and Committee oversight, prioritisation and decision-making.

Governance Route	
***Where** it's been:*	ORMG
***When** it went:*	30 Oct 26
***What** decision was made:*	NA

Main Report: *Background & Current Situation*

The Health Board now holds its detailed risks in a single Organisational Risk Register, which supports the shorter thematic Corporate Risk Register approved by the Board in September 2026. The current extract contains 153 extreme risks scoring 20 to 25: 134 score 20 and 19 score 25. Of these, 87 are recorded as Treat and 66 as Tolerate. Capital Estates and Facilities holds 69 risks, showing a continued concentration of infrastructure-related risk. The detailed report below explains the reporting journey, thematic links, current profile, age of risks, governance arrangements, assurance and limitations.

1. Purpose and overall position

Overall risk position and direction: The Health Board now holds its risks in a single Organisational Risk Register. This report explains how risk reporting has developed since May 2026 and how the Organisational Risk Register now supports the thematic Corporate Risk Register approved by the Board.

The current extract includes 153 extreme risks scoring between 20 and 25. These risks do not replace the approved thematic Corporate Risk Register. They provide the detailed information that sits behind it and show where the highest-rated risks are held, how long they have been open and whether they are being treated or tolerated.

153	134	19	87	66	69
extreme risks	score 20	score 25	Treat	Tolerate	CEF risks

2. Background and the reporting journey

The May 2026 report included all risks scoring 20 or above and used graphs to describe the Health Board's risk profile. At that time there were 200 risks scoring 20 or above, including 18 risks scoring 25. The report also confirmed that risks had moved to a single digital system and that the Task and Finish Group would become the Organisational Risk Management Group (ORMG).

The reports taken to Audit Committee and the Board in September 2026 built on this work. They recognised that a list of every risk scoring 20 or above was too large to support a focused Board discussion. A new thematic Corporate Risk Register was therefore developed to bring together the main risks that affect the Health Board as a whole.

The risk framework now has three connected parts:

1. Board Assurance Framework: sets out the strategic context and links the Health Board's objectives, portfolios, assurance and strategic risk themes.
2. Thematic Corporate Risk Register: provides a shorter view of the main risks affecting the Health Board as a whole. It was approved by the Board in September 2026.
3. Organisational Risk Register: holds the detailed risks managed by Clinical Boards and Corporate Directorates and allows different reports and views to be produced.

This means the Organisational Risk Register holds the detailed information, while the thematic Corporate Risk Register provides the shorter corporate view needed by the Board and its Committees.

Stage	Position	Purpose
May 2026	Corporate Risk Register containing all risks scoring 20 or above.	Show the detailed risk profile and confirm completion of the move to the digital system.
September 2026	Thematic Corporate Risk Register approved by the Board.	Provide a shorter and clearer view of the main risks affecting the Health Board as a whole.
October 2026	Risk Management Report based on 153 organisational risks scoring between 20 and 25.	Use current risk data to support the thematic register while keeping the extreme risks visible.

3. Link between the Organisational and Corporate Risk Registers

The 13 Corporate Risks approved by the Board in September 2026 were developed from the wider Organisational Risk Register. They do not replace the individual risks managed by Clinical Boards and Directorates. They bring together common causes, impacts and issues that need oversight at an organisational level.

The 153 extreme risks have been compared with the wording of the 13 Corporate Risks, using the risk title, event, cause, effect, themes, categories, gaps and barriers. This provides an indicative view of how the detailed risks support the thematic Corporate Risk Register.

Individual organisational risks can contribute to more than one Corporate Risk. The figures below show thematic links rather than separate categories and should not be added together. The mapping is based on text analysis.

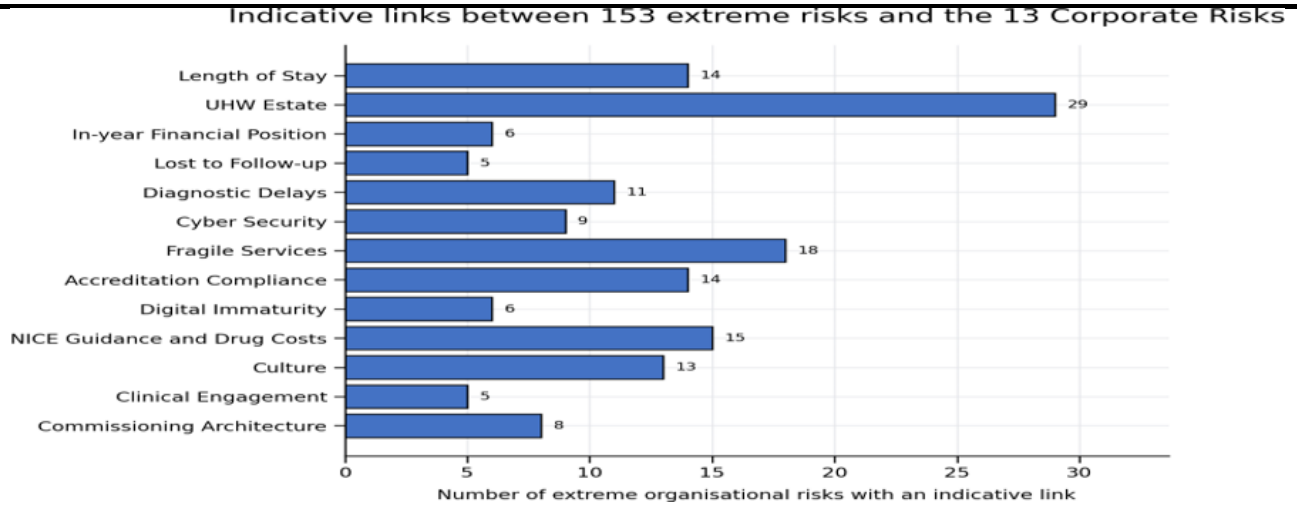

Figure 1: Indicative links between the 153 extreme Organisational Risks and the 13 Corporate Risks

Thematic Corporate Risk	Indicative linked risks	Share of 153
Length of Stay	14	9.2%
UHW Estate	29	19.0%
In-year Financial Position	6	3.9%
Lost to Follow-up	5	3.3%
Diagnostic Delays	11	7.2%
Cyber Security	9	5.9%
Fragile Services	18	11.8%
Accreditation Compliance	14	9.2%
Digital Immaturity	6	3.9%
NICE Guidance and Drug Costs	15	9.8%
Culture	13	8.5%
Clinical Engagement	5	3.3%
Commissioning Architecture	8	5.2%

The analysis shows the spread of links across all 13 Corporate Risks. It should be used as supporting evidence rather than as a final allocation. Its value is in showing whether the thematic Corporate Risk Register continues to reflect the main issues recorded in the Organisational Risk Register and where further review may be needed.

4. Current extreme-risk profile

The current extract contains 153 extreme risks. Of these, 134 are scored at 20 and 19 are scored at 25. This is 47 fewer risks than the 200 reported in May 2026. The number of risks scoring 25 has increased from 18 to 19. This comparison shows how the register has changed, but it does not on its own mean that the overall risk position has improved or worsened. Risks may have been closed, rescored, combined, added or removed through ongoing review and data cleansing.

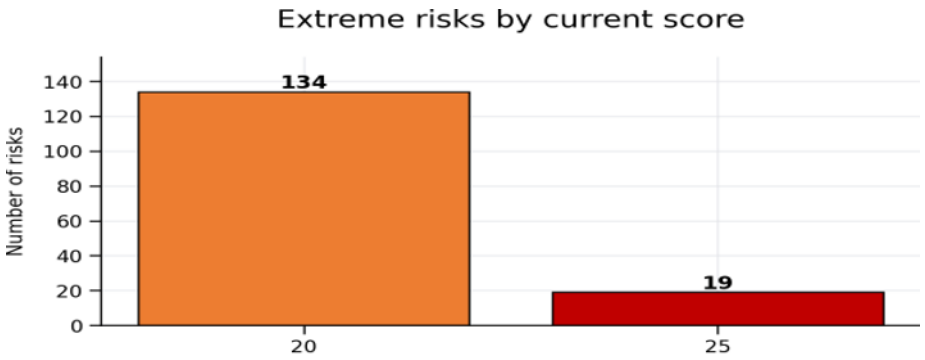

Figure 2: Extreme risks by current score, 19 October 2026

Of the 153 risks, 87 are being treated and 66 are being tolerated. This represents 57% Treat and 43% Tolerate, compared with 55% and 45% respectively in May 2026. The position is therefore broadly similar, with a small increase in the proportion being treated. The response selected does not by itself show whether a risk is being managed effectively. This must be considered alongside the controls, assurance, gaps and actions recorded for each risk.

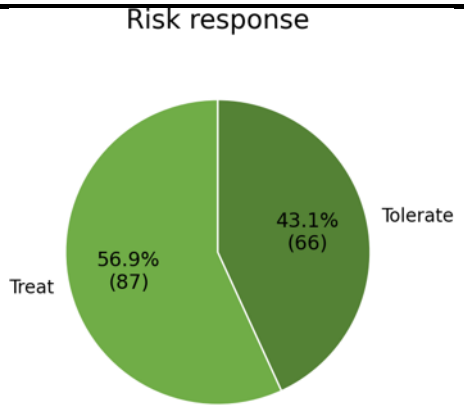

Figure 3: Recorded response to extreme risks

5. Distribution and concentration

The risks are not spread evenly across the Health Board. Capital Estates and Facilities holds 69 of the 153 risks, followed by Specialist Services with 26 and Medicine with 17. This continues to show the significant level of risk linked to infrastructure, while the wider register also includes a broad range of clinical and operational risks.

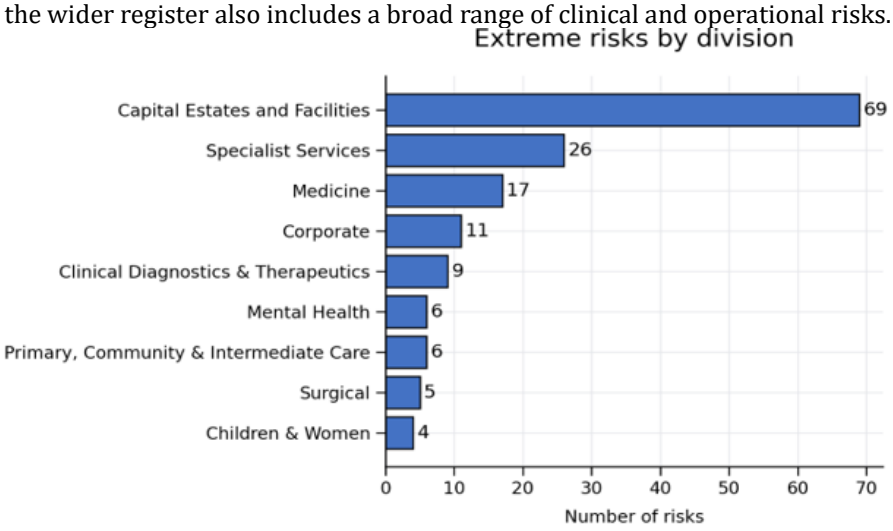

Figure 4: Extreme risks by division

A risk can be linked to more than one category. The most commonly used categories are Infrastructure, Operational risks and Quality risks. The figures in the graph should not be added together because some risks appear under more than one category.

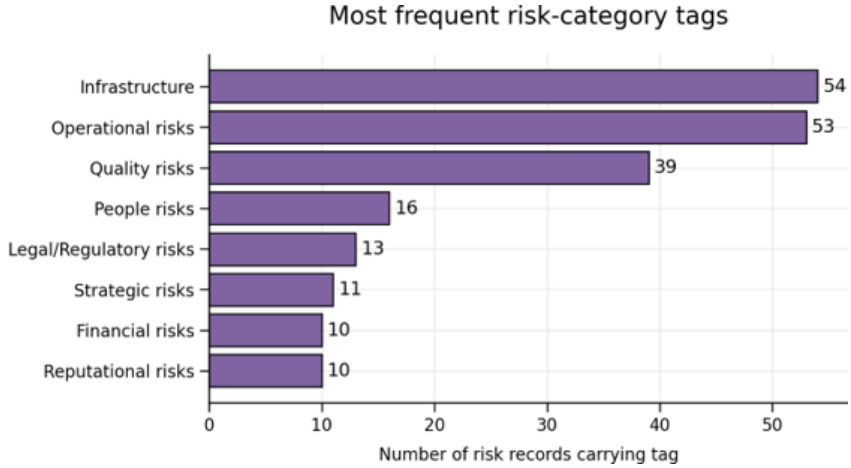

Figure 5: Most frequent risk-category tags (multiple tags may apply)

6. Age and legacy-risk profile

The length of time a risk has remained open is important when reviewing the register. Long-standing risks should continue to be checked to make sure the description, score, controls and actions remain current. Two risks have been open for at least 10 years and 41 were raised within the last 12 months. The oldest risk is “Storage of items in The Void in UHL Theatres”, raised on 20 October 2014.

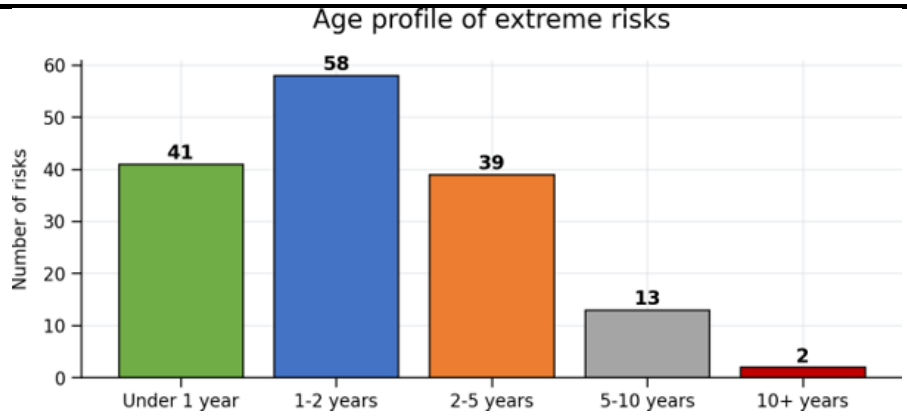

Figure 6: Age profile of extreme risks as at 19 October 2026

7. Risks scoring 25

Nineteen risks are currently scored at 25. These are listed below to give the Committee clear sight of the highest-rated risks. Further information on their controls, assurance, gaps, barriers and actions is held in the Organisational Risk Register and continues to be reviewed through the relevant management and governance arrangements.

Risk title	Division	Date raised	Response	Target
UHW High Voltage Load Shedding Equipment	Capital Estates and Facilities	20/11/2023	Tolerate	5
M36 - UHW & UHL Medical Gas Pressure Reducing Sets.	Capital Estates and Facilities	01/01/2021	Treat	5
Plant Room Roofs - UHW. Profiled steal sheeting	Capital Estates and Facilities	02/08/2021	Tolerate	10
Energy Cost Pressures - instability within the energy markets.	Capital Estates and Facilities	14/08/2025	Tolerate	5
Increased waiting times for surveillance and planned recall (e.g. gastric ulcer follow up) endoscopy procedures	Medicine	09/11/2020	Treat	4
there is not a robust method of risk stratifying patients based on current, evidence based guidance for surveillance.	Medicine	28/03/2024	Treat	9
Risk to the organisation of losing JACIE accreditation for the South Wales Blood & Marrow Programme.	Specialist Services	30/07/2025	Treat	10
Psychology waiting times	Medicine	11/08/2021	Treat	5
Risk to Colorectal peritoneal Metastases service (CRS/HIPEC) not being available	Surgical	07/08/2024	Treat	5
Lack of capacity in the Interstitial Lung Disease (ILD) Service.	Medicine	21/11/2024	Tolerate	6

Failure to Enter CF Patient Data into National Registry Due to Vacant Administrative Post	Medicine	28/11/2025	Treat	4
Vacant CF Clinical Nurse Specialist Post – Risk to CFRD Patient Care and Compliance with National Standards	Medicine	23/07/2025	Treat	10
Main Steam Header and Valves - UHW	Capital Estates and Facilities	29/11/2024	Tolerate	5
Lack of patient isolation facilities in UHW Critical Care Unit	Specialist Services	12/07/2022	Treat	1
Staffing Crisis in Cardiac Physiology (admin & physiology)	Specialist Services	03/10/2025	Treat	3
Risk of deaths in patients with cardiac devices	Specialist Services	03/11/2025	Treat	3
SCBC_Plastics Dressings Clinic	Specialist Services	01/04/2025	Treat	1
E18 - UHW LGF Switch Room 4	Capital Estates and Facilities	09/06/2025	Treat	5
Combined Heating and Power Plant (CHP)	Capital Estates and Facilities	28/02/2025	Treat	5

8. What the current data indicates

The move to a thematic Corporate Risk Register has not removed the detailed risks from view. It has separated the full operational information from the shorter corporate view needed by the Board.

The reduction from 200 risks in May to 153 in the current extract reflects changes made through ongoing review and data cleansing. It should not be taken on its own as evidence that the Health Board's overall risk exposure has reduced.

The number of Capital Estates and Facilities and Infrastructure risks shows the need to continue using risk information when considering capital priorities and operational resilience.

The 19 risks scoring 25, together with the long-standing extreme risks, require continued review and challenge. Particular attention should be given where the current score remains well above the target or where controls and assurance are limited.

The indicative mapping shows how the 153 extreme risks connect to the 13 thematic Corporate Risks. The Organisational Risk Register should continue to be used to check that those themes remain current, reflect the underlying risk position and are supported by clear actions.

9. Governance, oversight and next steps

Clinical Boards and Directorates will continue to own and review their risks, controls, assurance, gaps and actions.

The ORMG will use the register to identify common themes, differences in scoring, long-standing risks and areas where further support or data cleansing is needed.

Clinical Board reviews and executive meetings will continue to focus on the main risks and the progress being made to reduce them.

Board Committees will receive the relevant thematic corporate risks, supported by the detailed organisational risks within their areas of responsibility.

The Board will receive the thematic Corporate Risk Register at the agreed times, supported by analysis showing changes in the register, areas of concentration, new risks and progress with actions.

Future reports will continue to use graphs and data, as in the May report, but will also explain what has changed, where risks are concentrated and whether the thematic Corporate Risk Register continues to reflect the detailed register.

Appendices:

Appendix 1: Supplementary folder - Organisational Risk Register extract generated 19 October 2026.

Strategic Alignment – Shaping Our Future Wellbeing:

Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

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

Impact Assessment

Risk: No

The report is specifically concerned with organisational risk but it doesn't introduce risk

Safety: No

Not applicable.

Financial: No

Not applicable.

Workforce: No

Not applicable.

Legal: No

Not applicable.

Reputational: Yes

Failure to manage the risks described could have reputational implications for the Health Board. Oversight is provided through Clinical Boards, Directorates, Committees, the ORMG and the Board.

Socio Economic: No

Not applicable.

Equality & Health: No

Not applicable.

Decarbonisation: No

Not applicable.

Welsh Language: No

Not applicable.

Report Title: *(needs to match agenda)*	Procurement Compliance Report		Agenda Item No:		2.4
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	03.11.26
		Private			
Lead Executive Title:	Executive Director of Finance				
Report Author/s Title:	Deputy Director of Procurement Services and Executive Procurement Lead – C&V				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The Committee is advised that 19 instances of non-compliant procurement activity, with a total value of £346,378, were identified during the period 1 August to 31 October 2026. This represents a substantial reduction compared with the £2,387,998 reported for the previous period. A further two instances related to emergency or unforeseen activity and five exemptions permitted under the Standing Financial Instructions were recorded. Procurement Services continues to address the underlying causes through targeted training, strengthened early-engagement and contract-monitoring arrangements, improved documentation of exemptions and enhanced digital monitoring.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**		**Information/Noting**	X

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

The Audit and Assurance Committee are requested to NOTE the contents of the Report.

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	*N/A*
***When** it went:*	*N/A*
***What** decision was made:*	*N/A*

Main Report

Background & Current Situation

It is widely recognised that the Health Board is required to procure all goods and services in accordance with applicable legislation, Standing Orders (SOs), Standing Financial Instructions (SFIs), and recognised good procurement practice. This includes adherence to established thresholds for quotations and competitive tendering arrangements. The

procurement process operates within a robust legal framework designed to ensure transparency, fairness, accountability, and value for money in the use of public funds.

NWSSP Procurement Services influences a significant proportion of the Health Board's non-pay expenditure. However, there are circumstances where a competitive procurement process cannot be applied due to operational, clinical, legal, or statutory requirements. Such circumstances are permitted within the Health Board's SOs and SFIs and include areas where there is no practical alternative to competition, or where patient safety, continuity of care, or legislative obligations take precedence.

Examples include expenditure relating to accreditation required to meet regulatory requirements, rent and rates, and other requirements where the nature of the service or statutory obligation exempts the expenditure from a competitive procurement exercise. In recognition of these situations, Single Quotation Actions (SQAs) and Single Tender Actions (STAs) may be requested and approved in accordance with the Health Board's Procedure for the Approval of Single Tender Actions.

It should also be noted that the number of STA and SQA requests has reduced significantly in recent years. This improvement reflects the benefits of enhanced procurement training, increased utilisation of competitive procurement and transparent procurement processes, and collaborative work between NWSSP Procurement Services and Clinical Boards to establish longer-term contractual arrangements.

Whilst internal and external audit reviews may identify certain categories of expenditure as non-compliant, this can include expenditure that is legitimately exempt from competition and outside the influence of NWSSP Procurement Services. In these cases, the procurement route may be compliant due to the exemption; however, the expenditure may still be reported as non-compliant where the required approvals have not been obtained in accordance with the Health Board's Standing Orders, Standing Financial Instructions, and financial governance arrangements. Consequently, audit reports may record such expenditure as non-compliant despite there being a valid reason why a competitive procurement process could not be undertaken.

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (19)

This category of expenditure arises where departments have procured goods or services directly from suppliers without the involvement of NWSSP Procurement Services. In doing so, the departments have circumvented the Health Board's approved procurement processes and incurred a direct breach of Standing Financial Instructions (SFIs).

Description Title	Value at Risk Excl VAT	Length at Risk/ Breach	Clinical Board	Reason	Action/Status
PAYMENT OF INVOICE FOR VARIOUS RETROSPECTIVE SPEND ORDERS OVER 3 DIFFERENT ORDERS	£17,351.00	Retrospective POI	Capital, Estates and Facilities	No engagement with Procurement Services occurred prior to the requisition being raised.	The end user was contacted regarding repeated expenditure and advised of the need to engage Procurement Services in a timely manner to ensure a compliant route

					to market is undertaken and appropriate contractual arrangements are put in place.
SGS SURVEILLANCE ISO 13485:2016, UK MDR MEDICAL DEVICE AUDIT ON 21 JULY TO 22 JULY 2026	£10,548.00	Retrospective POI	Surgery	Essential audit in line with ISO accreditation	Procurement Services was not involved prior to the order being raised. The end user has subsequently been contacted and advised that, should the requirement continue, an appropriate procurement process must be completed and any necessary contractual arrangements established before any further orders are placed.
CHEMOTHERAPY PAYMENTS TO CITIGLOBE PHARMACY CHILDRENS HOSPITAL	£6,727.05	Jan 26 to Jun 26	Executives	No engagement with Procurement Services occurred prior to the requisition being raised. Retrospective Payment of Invoice	Procurement Services advised the stakeholder that they were in breach of the Health Board's Standing Financial Instructions (SFIs)
RETROSPECTIVE PAYMENT OF INVOICE FOR ESSENTIAL WORK CARRIED OUT BY HSL FOR PATHOLOGY WORK	£6,735.99	July 26 to August 26	Clinical Diagnostics and Therapeutics	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services was not involved prior to the order being raised. The end user has subsequently been contacted and advised that, should the requirement continue, an appropriate procurement process must be completed and any necessary contractual arrangements established

					before any further orders are placed.
REMOVAL OF MODULAR BUILDING PENTYRCH SURGERY	£8,872.50	One-off requirement	PCIC	No contract in place.	Re-imbursing of funds.
AGENCY STAFF	£8,383.28	September 2026	Capital, Estates and Facilities	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services looking with the Department to move away from agency staff and if this is not feasible to implement an agreement.
SUNCHIP 2 OPEN SET over 2 orders	£30,919.25	One-off requirement	Children & Women	No engagement with Procurement Services occurred prior to the requisition being raised.	Finance not authorising procurement report, have had discussions with supplier regarding a fixed price, ongoing requirement, going to be repeatedly reported to AC as procurement report stuck at signature
OUTCOMES INSTRUMENTS LLC INVOICE – LICENCE RENEWALS	£5,750.00	3 Years	Clinical Diagnostics and Therapeutics	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services discussed the requirements of the Standing Financial Instructions (SFIs) with the service to support compliance in future procurement activity. Added to procurement Workplan to pick up when due for renewal.
EMDR TRAINING	£6,341.67	One-off requirement	Mental Health	No engagement with Procurement Services occurred prior to the requisition being raised.	There was no involvement from Procurement Services prior to the commitment being made, with the end user signing the agreement directly, resulting in a retrospective

					approval request. Procurement Services discussed the requirements of the Standing Financial Instructions (SFIs) with the service and reinforced that all procurements exceeding £5,000 must be referred to Procurement Services before any commitment is made.
NORTH CARDIFF MEDICAL CENTRE GPN C5 NT AND ST ISAN ROAD SURGERY GPN COHORT 5SL SALARY AND EDUCATION	£34,590.00	One-off requirement	PCIC	No Procurement Involvement	Review of ongoing requirements to be established with compliant governance to support any future arrangement.
RP900X ALLPLEX X 2	£5,230.00	One-off requirement	Specialist Services	No procurement involvement - Contract in place but for different requirements, urgency approved	Procurement Services has contacted the end user to determine whether this is an ongoing requirement. If a long-term need is identified, work will commence to establish an appropriate compliant contractual arrangement.
NRP STAFF MASTERCLASS EDINBURGH NRP	£5,400.00	One-off requirement	Specialist Services	No Procurement involvement - Required training and class for organ work	Procurement Services has contacted the end user to determine whether this is an ongoing requirement. If a long-term need is identified, work will commence to establish an appropriate compliant contractual arrangement.

VISIO, POWER AUTOMATE AND POWER APPS LICENCES	£126,014.25	September 2026 to June 2027	Executives	No procurement involvement	This is available to contract via a framework and needs to be reviewed on a HB wide approach to ensure all current licences are covered by a formal agreement with contingency for adding additional licences for new users.
STUDY GRANT	£10,000.00	One-off requirement	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	Approved as a one-off study Grant.
TEST KIT 500 - SENSOR 500 TESTS / FILTERS AND BREATHING HANDLE - FOR ASTHMA SERVICE	£6,208.00	One-off requirement	Medicine	No procurement involvement - urgently require the goods due to low stock	Procurement Services discussed the matter with the department and will be looking to put a contract in place to add items on catalogue as this is a long-term usage.
SUPPLY AND INSTALL OF AC EQUIPMENT, DX MATERIALS AND DX SYSTEM	£5,270.00	One-off requirement	Capital, Estates and Facilities	No procurement involvement - kit is needed urgently as current equipment is end of life and Terratherm are not available on any frameworks.	Procurement Services reminded the department of its obligations under the Standing Financial Instructions (SFIs) and relevant procurement regulations. Procurement training has also been offered to improve understanding of procurement processes and when engagement with Procurement Services is required.

MEWS PMS ESSENTIALS	£9,816.00	One-off requirement	Capital, Estates and Facilities	No engagement with Procurement Services occurred prior to the requisition being raised and work already started.	Procurement Services discussed with the end users that all procurement activity with a value exceeding £5,000 must be referred to Procurement Services before any commitment is made, to ensure compliance with procurement regulations and contractual requirements.
CLEARTECH AUDIO, SCENIC, VISION, LIGHTING, TRANSPORT, CREW AND ADDITIONAL ITEMS FOR 2026	£9,250.00	One-off requirement	Capital, Estates and Facilities	Retrospective Payment of Invoice	Procurement Services contacted the end user to explain the requirements of the Standing Financial Instructions (SFIs) and to establish whether there is an ongoing requirement for the service, which may necessitate a compliant contractual arrangement.
CONFERENCE SERVICES	£5,466.00	One-off requirement	Clinical Diagnostics and Therapeutics	No procurement involvement - required course generation for 57 delegates	No formal contract was put in place for this requirement. Procurement Services has engaged with the end user to determine whether there is an ongoing need for the service and, should future expenditure arise, will work with the department to establish a compliant contractual arrangement.

SECURE TRANSPORT FOR MENTAL HEALTH	£17,130.00	Ongoing	Mental Health	No engagement with Procurement Services occurred prior to the requisition being raised.	The tender is currently open for submissions, with a contract award anticipated following completion of the evaluation process. The expected contract commencement date is 1 January 2027.
HOME HD ROOM CONVERSION INCLUDING DECOMMISSION OF EXISTING INSTALLATION. NEW HOME DX INSTALLATION CARRIED OUT.	£5,210.00	One-off requirement	Specialist Services	Retrospective Payment of Invoice	Procurement Services advised the stakeholder that they were in breach of the Health Board's Standing Financial Instructions (SFIs)

Contracts value breached/extended at risk as a result of emergency/unforseen circumstances (0)

Other Non-Compliant Activity (2)

This section details activities which were out of the Department/Health Boards 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
UPGRADE TO VRF SYSTEM SERVING ULTRASOUND ROOMS 1-7 AND EMERGENCY WORK PRESSURE LEAK COLD ROOM REPLACEMENT	£85,928.00	One-off Requirement	Capital Planning Estates and Facilities	Emergency Activity	Agreed as one-off unexpected unplanned spend
EMERGENCY HIRE OF PORTABLE COOLING SYSTEM TO SUPPORT THE TEMPORARY LOCATION OF HAEMATOLOGY DAY CLINIC TO 2ND FLOOR OF LAKESIDE WING	£16,375.40	One-off Requirement	Capital Planning Estates and Facilities	Emergency Activity	Agreed as one-off unexpected unplanned spend

Exemptions (5) (Permitted within SFIs)

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status

LEGAL SERVICES ACROSS VARIOUS LOCATIONS FOR THIS PERIOD	£114,691.28	One off requirement	Executives	Exemption	This expenditure is exempt under Legal Services.
PAYMENT OF INSURANCE FOR UNITS 1&6 WEQAS	£5,089.31	One off requirement	Clinical Diagnostics and Therapeutics	Exemption	Not applicable - Exempt rent.
LEASE PAYMENT / SERVICE CHARGE OF LEASE – VARIOUS ORDERS	£35,407.17	1 month	Capital Planning Estates and Facilities	Exemption	Not applicable - Exempt lease charges.
TUITION FEES VIA UNIVERSITY PARTNERSHIP	£11,660.00	One off requirement	Mental Health	Exemption	Not applicable - Exempt.
WHOLE SCHOOL APPROACH TO EMOTIONAL AND MENTAL WELLBEING	£61,456.00	01/04/2026 – 31/03/2027	Executives	Exemption	Exempt via Horizontal Arrangements – Partnership with Cardiff Council for joint outcomes.

It should be noted that Procurement Services has scheduled targeted training sessions with areas demonstrating higher levels of non-compliance relating to Standing Financial Instructions (SFIs), procurement legislation and regulatory requirements. This proactive approach aims to reduce the number of reported breaches across Clinical Boards. In anticipation of the recurring year-end budget pressures, Clinical Boards will also be reminded of their obligation to engage with Procurement services at an early stage when considering the procurement of goods and/or the appointment of service providers. Early engagement will help ensure that the appropriate procurement route is identified and followed, supporting compliance with legislative, regulatory and organisation requirements.

Report on Single Tender/Quotations Actions

Retrospective - (Nil Return)
Prospective (within the permitted guidelines)

The report outlines all SQA/STA (0) requested during the period from 1st August 2026 to 31st October 2026

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type	

Non-Compliant Activity / Contract Breach Summary

The summary below details all Clinical Boards that have been reports for non-compliant procurement breaches and exemptions during the reporting period, together with their corresponding figures from previous financial years for comparative purposes. This enables trends to be identified and provides context regarding levels of compliance across the organisation over time.

	2023/24 (FY)		2024/25 (FY)		2025/26 (YTD)	
Clinical Board	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption
AWMGS	14	0	15	2	4	1

Children and Women	11	0	8	3	6	0
Capital Planning, Estates and Facilities	17	7	20	29	17	2
Clinical, Diagnostics and Therapies	27	4	29	18	11	2
Executives	35	20	11	7	13	4
Medicine	3	0	9	0	1	0
Mental Health	10	0	4	4	3	1
PCIC	11	0	6	6	3	0
Specialist	11	2	10	2	5	2
Surgery and Dental	8	1	5	0	3	0
TOTALS	147	34	117	70	66	12

Total value of non-compliant Activity

1st May 2026 – 31st July 2026	£2,387,998
1st August 2026 – 31st October 2026	£346,378

The Health Board recorded fewer instances of non-compliant activity during this reporting period compared with the same period in the preceding reporting period, demonstrating an overall improvement in compliance.

STA/SQAs by Department

	2023/24 (FY)		2024/25 (FY)		2025/26 (YTD)	
Clinical Board	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption	Non-Compliant Breaches	Exemption
AWMGS	14	0	15	2	4	1
Children and Women	11	0	8	3	6	0
Capital Planning, Estates and Facilities	17	7	20	29	17	2
Clinical, Diagnostics and Therapies	27	4	29	18	11	2
Executives	35	20	11	7	13	4
Medicine	3	0	9	0	1	0
Mental Health	10	0	4	4	3	1
PCIC	11	0	6	6	3	0
Specialist	11	2	10	2	5	2
Surgery and Dental	8	1	5	0	3	0
TOTALS	147	34	117	70	66	12

Summary of the Key Issues progress

There has been a significant decrease in the number of SQA/STA requests during this reporting period, with none being processed.

Work continues to address the key drivers of non-compliance across Clinical Boards. Procurement Services has observed ongoing fluctuations in non-compliant spend, primarily linked to exemption requests, emergency repair requirements and retrospective approvals. Awareness and understanding of Standing Financial Instructions (SFIs) continues to vary across directorates, with early engagement with Procurement Services remaining inconsistent. In addition, contract lifecycle management arrangements require further strengthening to support sustained compliance.

Targeted training activity is underway, with plans to introduce measurable key performance indicators (KPIs) to assess the effectiveness of training interventions and identify areas requiring additional support. Governance processes remain predominantly reactive due to limited early involvement in procurement activity; however, several improvement initiatives are currently being progressed. Procurement Services continues to enhance its digital monitoring capability through the use of Qlik Sense and AdviseInc, with longer-term plans to integrate these systems into a single governance dashboard to improve visibility, reporting and oversight.

A number of key improvement actions are also being developed, including the implementation of rapid-response arrangements for emergency requirements, mandated early engagement protocols, strengthened contract monitoring processes, and the comprehensive documentation of exemption requests to ensure robust, audit-ready justification. Whilst these measures will take time to become fully embedded, they are expected to deliver sustained improvements in compliance and support improved audit outcomes.

To further strengthen compliance and awareness, Procurement Services has developed an online procurement e-learning module, which is currently in the testing phase. Once finalised, the module will be rolled out across all Clinical Boards as part of the wider procurement training programme. The objective is to improve understanding of procurement requirements, responsibilities and routes to market, thereby reducing instances of non-compliant procurement activity.

It should be noted that there may be instances of non-compliant activity that have not yet been identified or reported. Such cases may emerge as departments review and clear outstanding invoices and payment commitments. Any additional breaches identified through this process will be reported within future reporting periods.

Appendices:
(List any appendices that will accompany this report).

N/A

Strategic Alignment – Shaping Our Future Wellbeing:
Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

Putting People First		Providing Outstanding Quality	x

Delivering in the Right Places	x	Acting for the Future	x

Impact Assessment *Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)*
Risk: Yes
Outlined above
Safety: No
Financial: Yes
Outlined above
Workforce: No
Legal: Please select
Outlined above
Reputational: Yes
Outlined above
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title: *(needs to match agenda)*	Counter Fraud Progress Report		Agenda Item No:		4.1
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	03/11/2026
		Private			
Lead Executive Title:	Catherine Phillips – Executive Director of Finance				
Report Author/s Title:	Henry Bales – Counter Fraud Manager				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The report provides assurance to the Audit and Assurance Committee that counter fraud activity is being progressed in line with the agreed work plan and the requirements of the NHS Counter Fraud Authority. It summarises activity across key areas including fraud awareness and learning, proactive prevention work, investigation and reactive activity, and promotional engagement.
No matters are presented for immediate alert or decision.

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**		**Information/Noting**	x

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

The committee are requested to: note the report

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	*Catherine Phillips – Executive Director of Finance*
***When** it went:*	
***What** decision was made:*	

Main Report

Background & Current Situation

Background

This report provides the Audit and Assurance Committee with an update on counter fraud activity during the reporting period, in line with the agreed work plan and NHS Counter Fraud Authority requirements.

Current Situation

Counter fraud activity continues to progress as planned across awareness, prevention, investigation and engagement work. No matters require immediate escalation or approval, and the Committee is asked to note the assurance provided.

Appendices:
(List any appendices that will accompany this report).

Counter Fraud Progress Report P3

Strategic Alignment – Shaping Our Future Wellbeing:
Please place an "X" against the strategic objective(s) this paper supports – Click the below tiles for further information.

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

Impact Assessment
Please ensure each section is completed. (If "Yes" is selected, complete the detail. If "No", please write "Not applicable".)

Risk: Yes

The report relates to the management of fraud, bribery and corruption risks through the delivery of counter fraud activity, including awareness, prevention, detection and investigation work. Any specific fraud risks identified through this activity are managed in accordance with established counter fraud processes and escalated where appropriate.

Safety: No

Not applicable

Financial: Yes

Counter fraud activity supports the protection of public funds by reducing the risk of financial loss through prevention, detection and investigation. No additional funding or financial approval is sought.

Workforce: Yes

Counter fraud activity has workforce implications through staff awareness, training and engagement, supporting employees to identify and report fraud concerns appropriately. No additional workforce resource is required as part of this report.

Legal: No

Not applicable

Reputational: Yes

Counter fraud activity supports public confidence by demonstrating that fraud risks are taken seriously and managed appropriately. Reputational risks are mitigated through prevention, awareness, investigation and escalation where required.

Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*

Not applicable

Equality & Health: No

Not applicable

Decarbonisation: No

Not applicable

Welsh Language: No
Not applicable

Counter Fraud Progress Report

17/08/2026 – 21/10/2026

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 17/08/2026 – 21/10/2026.

2. Progress

Infrastructure/Annual Plan

Work has continued to maintain the Counter Fraud infrastructure and support delivery of the Counter Fraud Plan for 2026/27, as well as compliance with the NHS CFA functional standards. The following 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, and in informing areas of future work.

ii. Continued maintenance of the Counter Fraud digital platform – Members of the Audit and Assurance Committee are encouraged to access the site using the link or QR code provided below.

Counter Fraud - Home (sharepoint.com)

Promotion, 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 other publications.

Awareness Sessions – The Counter Fraud team continues to participate in corporate induction events for new starters. During this period, two sessions have taken place, with short counter fraud awareness talks delivered to all attendees, reaching approximately 75 members of staff.

At the request of a GP practice, a further awareness talk was delivered to two members of its management team.

Prevention

IBURN/Alerts (intelligence bulletins) – (2)

Two bulletins were received during this period: one relating to fraudulent training suppliers and the other to CEO spoofing fraud. No CAVUHB-specific concerns were identified. Relevant intelligence-sharing and prevention measures were put in place.

National Fraud Initiative

All data has been submitted for the upcoming exercise. The release of matches is expected in December. Once available, a breakdown of the matches will be provided to the Committee, together with periodic updates on progress in reviewing them.

Fraud Risk Profile

Work is currently underway to refresh the organisation's fraud risk profile. This includes transferring existing risk assessments onto the Government Counter Fraud Profession template and undertaking higher-level assessments across a broad range of risks. The updated profile will be used to inform and prioritise areas for further focus. This is a significant piece of work, and efficiencies are being sought where possible through a coordinated approach across the five organisations covered by the team.

Referrals

During this reporting period, 49 referrals were made to the team. Of these, 15 have been promoted to investigation. Two referrals remain at the initial assessment stage. The remaining referrals have been reviewed and any actions completed without the need for escalation to formal investigations.

Investigations

During this reporting period, 15 investigations were commenced by the Counter Fraud team. 11 investigations were closed during the same period. This means that there are currently 14 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

The table below includes all investigations opened during the reporting period, including those that were subsequently closed within the same period.

Reference	Type	Subtype	Date Created	Close Date
INV/26/02764	NHS Staff Fraud - Employee fraud		18/08/2026	24/08/2026
INV/26/02824	NHS Staff Fraud - Employee fraud	Employee declaration	24/08/2026	12/10/2026
INV/26/02826	NHS Staff Fraud - Employee fraud	Working Whilst Sick	24/08/2026	
INV/26/02901	NHS Patient Fraud		03/09/2026	16/10/2026
INV/26/03014	NHS Staff Fraud - Employee fraud	Employee insider issues	14/09/2026	12/10/2026
INV/26/03101	NHS Staff Fraud - Employee fraud	Employee Fraud - Other	21/09/2026	
INV/26/03107	NHS Staff Fraud - Employee fraud		21/09/2026	
INV/26/03113	NHS Patient Fraud	NHS Patients - Misuse of prescriptions	22/09/2026	
INV/26/03184	NHS Staff Fraud - Employee fraud	Recruitment process	29/09/2026	
INV/26/03203	NHS Staff Fraud - Dental	Dental contract - patient claims	30/09/2026	16/10/2026
INV/26/03217	NHS Staff Fraud - Employee fraud	Employee Fraud - Other	05/10/2026	
INV/26/03323	NHS Staff Fraud - Pharmaceutical		12/10/2026	16/10/2026
INV/26/03355	NHS Patient Fraud	NHS Patients - Misuse of prescriptions	14/10/2026	16/10/2026
INV/26/03398	NHS Staff Fraud - Employee fraud	Working Whilst Sick	15/10/2026	
INV/26/03400	NHS Staff Fraud - Employee fraud	Employee declaration	15/10/2026	

Investigations closed in the period

Reference	Type	Subtype	Date Created	Close Date
INV/26/01340	NHS Staff Fraud - Pharmaceutical	Dispensing fraud - dispensing irregularities	21/04/2026	06/10/2026
INV/26/02156	NHS Patient Fraud	NHS Patients - Misuse of services	01/07/2026	24/08/2026
INV/26/02450	NHS Staff Fraud - Employee fraud	Timesheet/overtime fraud	27/07/2026	16/10/2026
INV/26/02711	NHS Patient Fraud	NHS Patients - Misuse of services	12/08/2026	16/10/2026
INV/26/02764	NHS Staff Fraud - Employee fraud		18/08/2026	24/08/2026
INV/26/02824	NHS Staff Fraud - Employee fraud	Employee declaration	24/08/2026	12/10/2026
INV/26/02901	NHS Patient Fraud		03/09/2026	16/10/2026
INV/26/03014	NHS Staff Fraud - Employee fraud	Employee insider issues	14/09/2026	12/10/2026
INV/26/03203	NHS Staff Fraud - Dental	Dental contract - patient claims	30/09/2026	16/10/2026
INV/26/03323	NHS Staff Fraud - Pharmaceutical		12/10/2026	16/10/2026
INV/26/03355	NHS Patient Fraud	NHS Patients - Misuse of prescriptions	14/10/2026	16/10/2026

Investigations that remain open

Reference	Type	Subtype	Date Created	Close Date
INV/25/02716	NHS Staff Fraud - General Practitioner	GP Practice - Prescribing	15/09/2025	
INV/26/00131	NHS Patient Fraud	NHS Patients - Misuse of prescriptions	15/01/2026	
INV/26/01801	NHS Staff Fraud - Employee fraud	Employee Fraud - Other	03/06/2026	
INV/26/02219	NHS Staff Fraud - Employee fraud	Working Whilst Sick	07/07/2026	
INV/26/02719	NHS Staff Fraud - Employee fraud	Timesheet/overtime fraud	13/08/2026	
INV/26/02720	NHS Staff Fraud - Employee fraud	Timesheet/overtime fraud	13/08/2026	
INV/26/02826	NHS Staff Fraud - Employee fraud	Working Whilst Sick	24/08/2026	
INV/26/03101	NHS Staff Fraud - Employee fraud	Employee Fraud - Other	21/09/2026	
INV/26/03107	NHS Staff Fraud - Employee fraud		21/09/2026	
INV/26/03113	NHS Patient Fraud	NHS Patients - Misuse of prescriptions	22/09/2026	
INV/26/03184	NHS Staff Fraud - Employee fraud	Recruitment process	29/09/2026	
INV/26/03217	NHS Staff Fraud - Employee fraud	Employee Fraud - Other	05/10/2026	
INV/26/03398	NHS Staff Fraud - Employee fraud	Working Whilst Sick	15/10/2026	

3. Significant Salary Overpayments

There have been three significant salary overpayments reported for this period. These have been reviewed by the Counter Fraud team and did not require progression to formal criminal investigation.

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

The Counter Fraud team has 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.

The policy defines "significant" overpayments as those with a total value of more than £5,000 which have continued for more than three 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.

4. Work completed for other organisations under SLA Agreement

The Cardiff and Vale Counter Fraud team provides counter fraud services to four other NHS Wales organisations through SLA arrangements: Public Health Wales, Health Education and Improvement Wales, Digital Health and Care Wales, and Velindre University NHS Trust.

A detailed breakdown of the work undertaken for each organisation is provided to its respective Audit and Assurance Committee. A brief summary of activity across the four organisations is provided below.

Awareness Sessions

During this period, 15 awareness sessions have been provided to a total of 634 people across the 4 organisations.

Referrals

During this period, a total of 11 referrals were received across the 4 organisations.

Investigations

During this period, 1 investigation was opened. 4 investigations were closed. 2 investigations remain open and under investigation.