AUDIT AND ASSURANCE COMMITTEE

Tuesday 1 September 2026 at 09:00am

PUBLIC MEETING

09:00	**1. Preliminaries**	
1.1	**Welcome, Introductions & Apologies for Absence:**	David Edwards
1.2	Declarations of Interest	David Edwards
1.3	Minutes of the Committee meetings held: 19.05.2026 & 23.06.2026	David Edwards
1.4	Actions following meeting held: 19.05.2026	David Edwards
1.5	Any Other Urgent Business	David Edwards
09:10	**2. Items for Review & Assurance**	
09:10 2.1 20 mins	Internal Audit Progress Report including: • Leadership & Management Training/Development (Reasonable Assurance) • Five Steps to Safer Surgery (Reasonable Assurance) • Medicines Management (Reasonable Assurance) • Local / Shadow IT (Reasonable Assurance) • *Flexible Working Arrangements for Compressed and Variable Hours (Limited Assurance)* • *Reducing Health Inequalities – Ethnicity Data (Unsatisfactory Assurance)* • Space Utilisation (Advisory) • Speaking Up Safely (Reasonable Assurance) • ALAS Equipment Purchasing & Stock Management (Reasonable Assurance) • *Follow-ups Not Booked (From 25/26 plan) (Limited Assurance)*	Ian Virgil
09:30 2.2 10 mins	Thematic Review Internal Audit	Ian Virgil
09:40 2.3 10 mins	Audit Tracker Update	Matt Phillips
09:50 2.4 15 mins	Audit Wales Update including: - *Clinical Coding Progress Review* - *Are Cancer Services Improving?* - *Digital Transformation*	Audit Wales
10:05 2.5 10 mins	Procurement Compliance Report	Catherine Phillips
10:15 2.6 10 mins	Post Payment Verification – End of Year Report 2025-26	Catherine Phillips Amanda Legge
10:25 2.7 10 mins	Car Parking Procurement – Lessons Learnt	Catherine Phillips Claire Salisbury
10:35 2.8	Corporate Risk Register	Matt Phillips

10 mins		
10:45	**3. Items for Approval/Ratification**	
	No items	
10:45	**4. Items for Noting & Information**	
4.1	Counter Fraud Progress Update	Henry Bales
10:45	**5. Agenda for Private Audit and Assurance Committee**	
	i. Approval of Minutes *ii. Counter Fraud Progress Update (Confidential – ongoing investigations)* *iii. People & Culture Assurance Report*	
10:45	**6. Any Other Business**	
10:45	**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 3 November 2026	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 19 May 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
Mike Jones	MJ	Independent Member – Trade Union
Rhian Thomas	RT	Independent Member for Capital and Estates
Kirsty Williams	KW	UHB Chair
In Attendance:		
Henry Bales	HB	Lead Local Counter Fraud Specialist
Samuel Barrett	SB	Director of Operations Mental Health
Rachel Freitag	RF	Audit Manager – Audit Wales
Rachel Gidman	RG	Executive Director of People and Culture
Kartina Griffiths	KG	Associate Director of People and Culture
Lucy Jugessur	LJ	Deputy Head of Internal Audit
Robert Mahoney	RM	Deputy Director of Finance
Lianne Morse	LM	Deputy Director of People & Culture
Urvisha Perez	UP	Audit Lead - Audit Wales
Catherine Phillips	CPH	Executive Director of Finance
Matt Phillips	MP	Director of Corporate Governance
Frankie Ogden	FO	Head of Corporate Governance
Ian Virgil	IV	Head of Internal Audit
Catherine Wood	CW	Deputy Chief Operating Officer
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Rachna Upadhya	RU	Independent Member

Item No	Agenda Item	Action
A&A 26/05/1.1	**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 26/05/1.2	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
A&A 26/05/1.3	**Minutes of the Committee meeting held 03.02.2026** The Minutes of the Meeting Held on the 03.02.2026 were received. **The Committee resolved that:** a) The draft minutes of the meetings held on 03.02.2026 were deemed to be a true and accurate record of the meeting.	
A&A 26/05/1.4	**Actions following meeting held: 03.02.2026 (click to view)** The Actions were received. It was noted that all actions had been moved to the Forward Plan.	

	The Committee resolved that: a) The Actions were noted	
A&A 26/05/2.1	**Internal Audit Progress Report** Ian Virgil (IV), Head of Internal Audit presented the Internal Audit Progress Report and provided an update on progress against the 2025/26 Internal Audit Plan. He noted that an additional audit had been incorporated into the Plan following the decision to separate the Neurodevelopmental Services review into distinct audits for adult and children's services, resulting in two final reports. He further updated the Committee on the annual review of the Health Board's arrangements for tracking the implementation of Internal Audit recommendations and reported that sample testing had confirmed that actions recorded as complete within the AMAT system had been appropriately evidenced and implemented. Whilst a small number of actions relating to one audit had been incorrectly recorded as complete, he advised that these had subsequently been corrected and updated within the system. He concluded that the Committee could take reasonable assurance that the information contained within the audit action tracking system was accurate and complete. In response, DE reflected that the majority of audits presented had achieved either reasonable or substantial assurance, which had enabled the Committee to focus its discussion on those areas receiving lower assurance ratings. He noted that year-end Audit & Assurance Committee meetings were becoming increasingly congested and suggested that consideration be given to extending the duration of future May meetings to allow sufficient time for detailed scrutiny should a greater number of limited assurance reports arise. The Committee subsequently considered a number of individual audit reports. Lucy Juggessur (LJ), Deputy Head of Internal Audit presented the Occupational Health audit, which had received a substantial assurance rating. She advised that referral management arrangements, assessment timescales and pre-employment health checks were generally well controlled, whilst noting three medium-priority findings relating to the absence of a standalone Occupational Health policy, inconsistencies in published information and the absence of formal arrangements for KPI reporting. LJ also presented the Risk Management and Board Assurance Framework audit, which achieved reasonable assurance. She reported that significant progress had been made, particularly through implementation of the AMAT system and improved alignment between risks and strategic objectives. She advised that further work remained necessary to strengthen risk moderation processes, update elements of the risk management policy and reduce the size and complexity of the Corporate Risk Register. Presenting the Neurodevelopmental Services (Children) audit, LJ advised that reasonable assurance had been provided. Whilst acknowledging severe capacity pressures and waiting times exceeding three years, she noted that effective triage arrangements, communication processes and service redesign initiatives were in place. However, she highlighted ongoing concerns relating to workforce capacity, resilience, waiting list management and management information. IV then presented the audits relating to major capital schemes and nurse staffing levels. He reported that both the Ridgeway development and Wellbeing Hub projects had	

received reasonable assurance, with findings focused on governance, reporting and project management processes. He also advised that the Nurse Staffing Levels audit had provided reasonable assurance, confirming compliance with statutory requirements whilst identifying opportunities to strengthen documentation, safe care census compliance and the management of staffing red flag issues.

The Committee paid particular attention to three audits which had received limited assurance ratings.

Presenting the Managing Attendance at Work audit, IV reported that whilst the policy framework was established across the Health Board, there were material inconsistencies in implementation at ward and departmental level. He highlighted weaknesses relating to sickness absence recording, supporting documentation, policy review triggers and the timeliness of return-to-work meetings.

Katrina Griffiths (KG), Associate Director of People and Culture advised that actions had already been implemented in response to the findings, including enhanced training, strengthened oversight arrangements and continued monitoring through hotspot reviews. Lianne Morse added that the findings largely related to management behaviours and administrative processes and reported that sickness absence levels were beginning to reduce following interventions implemented over the previous twelve months.

IV presented the Staff Overpayments audit, which also received limited assurance. He advised that overpayments remained a material issue for the Health Board and were principally caused by delays in notifying leavers, changes to working hours and other workforce changes. He highlighted weaknesses in manager awareness, training provision and the consistent use of workforce systems.

In response, Lianne Morse (LM), Deputy Director of People & Culture advised that a refreshed working group and action plan had been established and that whilst challenges remained, overpayments were beginning to reduce, particularly in relation to payroll processing errors.

Finally, LJ presented the Neurodevelopmental Services (Adults) audit, which had also received limited assurance. She advised that significant concerns remained regarding the sustainability of adult ADHD services, growing waiting lists, fragmented management information and ongoing pressures on Community Mental Health Teams.

Samuel Barrett (SB), Director of Operations Mental Health welcomed the audit findings, advising that they aligned with other transformation and review work already underway. He explained that the service would prioritise development of a consistent triage model, review opportunities for service redesign and seek alignment with emerging national approaches to neurodevelopmental services across Wales.

IV advised that all agreed management actions arising from the audits would be recorded and monitored through the AMAT system. He further confirmed that follow-up reviews of all limited assurance audits had been incorporated into the draft Internal Audit Plan for 2026/27 and that progress would be reported back to future meetings of the Committee.

The Committee noted the report and took assurance from the work undertaken and the arrangements in place to monitor delivery of agreed actions.

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 2025/26 plan were approved.	
A&A 26/05/2.2	**Internal Audit Draft Annual Plan** IV introduced the Draft Internal Audit Plan for 2026–27, describing it as a comprehensive and structured programme of work designed to support the Health Board's governance, risk management, and internal control framework over the coming year. He advised that the Plan had been developed in accordance with the Global Internal Audit Standards and was underpinned by a risk-based methodology. This approach ensures that internal audit activity is prioritised towards areas of greatest organisational risk, aligning audit resources with the Health Board's strategic objectives and principal risks. In outlining the development process, IV emphasised the significant level of engagement undertaken across the organisation. The Audit team consulted individually with all Executive Directors to gather views on key risk areas, emerging issues, and proposed audit coverage. This engagement informed an initial long list of potential audits, which was subsequently refined through discussions with the Chief Executive, the Audit Committee Chair, and the Health Board Chair. The draft plan was then presented to the Strategic Leadership Team (SLT) to support prioritisation and ensure deliverability within available resources. IV noted that this iterative process had resulted in a balanced and proportionate audit plan, reflecting both organisational priorities and internal audit capacity. The final draft presented to the Committee contained 36 planned audit reviews for the year, each aligned to identified risks and supported by defined scopes, executive leads, and indicative timelines (set out in the Plan's appendices). He further clarified that while high-level scopes were included, the detailed scope of each audit would be agreed with relevant executives and management teams at the point of delivery, allowing flexibility to respond to evolving risks and organisational priorities. The Plan also confirmed that internal audit resources were considered sufficient to deliver the proposed programme, with provision for both core audit work and capital scheme assurance. Ian explained that audit costs associated with capital projects would be met through individual project business cases, ensuring transparency and appropriate resourcing of capital-related assurance activity. Additionally, the Plan included the Internal Audit Mandate and Charter, which defines the purpose, authority, and responsibilities of Internal Audit, and sets out the framework for its relationship with the Health Board. Ian advised that this remained consistent with previous years and aligned with professional standards and was presented for formal Committee approval. Members of the Committee did not seek detailed clarification on individual elements of the Plan, reflecting confidence in both the methodology and the clarity of the documentation. DE noted that the Plan was clearly presented and well-structured, providing assurance that it appropriately reflected organisational priorities and audit requirements.	

	The Committee resolved that: A) the Internal Audit Plan for 2026/27 was approved. B) The Internal Audit Mandate and Charter were approved. C) The associated Internal Audit resource requirements and Key Performance Indicators were noted.	
A&A 26/05/2.3	**Audit Wales Update** Urvisha Perez (UP), Audit Lead - Audit Wales introduced the Audit Wales Update, presenting both the routine progress update and the Audit Wales Annual Plan for 2026. She provided an overview of performance audit work currently underway and outlined planned areas of focus for the coming year. UP advised that the Clinical Coding Review and Digital Transformation Review had both been completed but were not finalised in time for presentation at this meeting. These reports would instead be brought to the Committee at its September meeting, ensuring Members had the opportunity to review the findings in full. In addition, she confirmed that fieldwork was ongoing for the Estates Management Deep Dive and the Local Cancer Services Review, with both also scheduled for reporting in September. Looking ahead, UP outlined the planned performance audit programme for 2026, highlighting a forthcoming thematic review focused on diabetes management and prevention. This work was expected to examine how NHS bodies were delivering against national ambitions, including implementation of key programmes such as the All Wales Diabetes Prevention Programme and associated high-value care pathways. She further informed Members that the local audit work for Cardiff and Vale UHB in the coming year would focus on operating theatre efficiency and effectiveness. This review remained at the planning stage, and while no firm reporting timetable had been confirmed, it is anticipated that findings would be presented later in the year once the scope was finalised. UP also noted that Audit Wales was currently reviewing its structured assessment approach, with details still being developed. She committed to providing a further update to the Committee once the plans were clearer. This was presented as part of Audit Wales' ongoing effort to refine and strengthen its approach to organisational assessment. In addition to forward-looking work, UP drew the Committee's attention to two recent national reports published by Audit Wales which may be of relevance: A review of the Regional Integration Fund, focusing on Welsh Government's progress in implementing previous recommendations and the effectiveness of oversight arrangements at a regional level. A national report on Additional Learning Needs (ALN), which included commentary on the role and contribution of health boards. While these reports did not contain direct recommendations for health boards, UP suggested that they may warrant consideration at a future Committee or alternative forum, particularly in relation to oversight responsibilities and partnership working across sectors.	

	Rachel Freitag (RF), Audit Manager - Audit Wales then presented the financial audit update and 2026 audit plan, focusing on progress with the 2025–26 accounts audit and the key audit risks identified. RF confirmed that audit work on the accounts was already underway, with no significant issues identified to date. She highlighted that the audit was progressing in line with the agreed timetable, with a target for certification and presentation of the accounts in June 2026. She explained that the materiality threshold for the audit had been updated based on the draft accounts, reflecting an increase in overall expenditure. This ensured that the audit approach remained proportionate and focused on areas of greatest significance. In terms of audit risks, RF confirmed that those remaiedn broadly consistent with previous years and included: • Management override of controls, a standard risk in all organisations • The failure to meet the first financial duty, which will require a modification to the regularity opinion • Risks associated with capital expenditure timing, particularly where significant spend occurred late in the financial year • The accuracy and compliance of senior remuneration and related party disclosures • The valuation of assets and provisions, given the level of judgement involved RF emphasised that the risks would be subject to detailed audit scrutiny as part of the ongoing work programme. She also outlined the audit fee arrangements, noting that fees were set in accordance with Audit Wales' published fee scheme and were designed to recover costs only, with any surplus returned or additional costs considered where necessary. Finally, RF informed the Committee of a change in audit leadership, with the previous Engagement Director having retired and a new Director, Tom Haslam, now appointed and engaging with health boards. A brief discussion arose regarding whether underpayments were captured alongside overpayments. RF confirmed that while underpayments were considered operationally, they were not currently reported to the Committee in the same way, although this could be reviewed if Members wished greater visibility. **The Committee resolved that:** a) The Audit Wales Update was noted.	
A&A 26/05/2.4	**Risk Management** Matt Phillips (MP), Director of Corporate Governance presented an update on the Health Board's approach to risk management, describing a significant period of transition from a fragmented and inconsistent system of multiple risk registers to a more cohesive and structured model centred on the AMAT platform. He reminded the Committee that previously the organisation had operated with a "myriad" of risk registers, making it difficult to maintain a clear, organisation-wide view of risk exposure.	

	In response, substantial work had been undertaken over the past several months, in partnership with AMAT, to design and implement a single, integrated risk management system. This has resulted in over 1,300 risks being migrated into a central repository, enabling improved visibility, consistency, and reporting across the Health Board. The new system provides flexibility in how risk data can be interrogated and used, supporting both operational management and strategic oversight. MP emphasised that the focus was now shifting from simply administering risks to actively using risk information to inform decision-making and organisational performance. To support that, a task and finish group responsible for overseeing the migration work had been formalised into an Organisational Risk Management Group. This group would act as the central operational forum for risk leads across Clinical Boards and directorates, enabling the sharing of best practice, ensuring consistent application of risk processes, and maintaining momentum in embedding the new system. It was noted that the Group would also play a key role in driving improvements identified through Internal Audit. MP further outlined how risk information was now being embedded within key governance processes. Risk reports were being systematically incorporated into Clinical Board performance reviews, with each Clinical Board required to present its top five risks. Those discussions were intended to align risk management more closely with broader organisational priorities, including performance management, financial planning, and quality improvement and represented a cultural shift towards using risk as an active management tool rather than a purely compliance exercise. MP acknowledged that further work was required to refine the system and ensure it operates effectively at all levels. A key issue highlighted was the size and complexity of the Corporate Risk Register, which included a very large number of risks. He noted that this presents challenges for meaningful oversight at Board level, as it became difficult to prioritise and maintain focus on the most significant risks. To address this, a programme of risk moderation and rationalisation was underway, including structured moderation sessions within Clinical Boards and planned review discussions at Strategic Leadership Team (SLT) level. MP confirmed that the activities would culminate in a further update to the Audit Committee later in the year. The discussion also highlighted the interdependency between service risks and estate-related risks, particularly within specialist services. In response to a query from DE regarding the high level of risk exposure in specialist services, MP explained that many of the risks were driven by underlying estate conditions, with impacts manifesting across a range of clinical services including cardiac, trauma, and haematology. Catherine Phillips (CP), Executive Director of Finance supplemented the explanation by emphasising that while estate risks were a significant driver, risks within specialist services also reflected broader issues relating to workforce, service delivery, and the ability to meet commissioned specifications. CP further noted that the new system was improving transparency by allowing clearer identification of where risks lie and who was responsible for addressing them.	

	She highlighted ongoing work to distinguish between risks that could be managed locally within Clinical Boards and those that required escalation to corporate or external levels for resolution. This clarity was expected to strengthen accountability and support more effective risk mitigation. **The Committee resolved that:** a) The contents of the Report along with the Corporate Risk Register and the continued progress was noted.	
A&A 26/05/2.5	**Policy Management** MP presented an update on policy management across the organisation, building on previous work to strengthen oversight and control through the use of the AMAT system. He explained that the Health Board had made significant progress in consolidating and managing its policy base following earlier internal audit findings, which had identified weaknesses in policy oversight. MP outlined that the overall number of policies within the organisation had increased, reflecting both the scale of the Health Board and the continued development and refinement of governance documentation. He emphasised that the increase should not necessarily be viewed negatively, as policies represented a key mechanism through which the organisation defined decision-making authority, roles, responsibilities, and expected standards of practice. He reflected on the substantial work undertaken in recent years to rationalise the policy base, including the removal of obsolete and duplicate policies, and the migration of policy records into AMAT. This enabled improved visibility of policy ownership, status, and review timelines, and provided a single source of truth for policy management. MP was clear that policy review timeliness remained a key area requiring improvement. While the proportion of overdue policies has begun to reduce over recent months, it remains higher than expected and was an area of continued focus. He noted that the apparent improvement in timeliness was partly attributable to increased scrutiny and active management rather than a fully embedded, sustainable process. To address this, MP described the introduction of a more structured and targeted approach using established governance forums. In particular, Clinical Board reviews were now being utilised as a key lever to drive improvement, with policy compliance and review data presented at each review. This enabled direct engagement with policy owners and Clinical Board leadership teams, reinforcing accountability and encouraging timely action. MP acknowledged that while review dates were important for maintaining control, the passage of time alone did not necessarily mean a policy had become ineffective or high risk. He noted that three-year review cycles could elapse without substantive change, and that in many cases, policies remained valid despite being technically overdue. He reinforced that governance standards required that review dates were adhered to and formally updated, and that this discipline would continue to be enforced. The Committee explored the distinction between policy existence and policy compliance, recognising that having a robust suite of policies did not in itself provide assurance that	

	they were being followed in practice. In response to a query from DE, MP explained that there was no single centralised mechanism for monitoring compliance across all policies, given the scale and diversity of the organisation, which held approximately 500 policies. Instead, assurance was derived from a combination of mechanisms, including: • Internal and external audits, which test compliance in specific areas • Committee oversight structures, aligned to relevant policy domains • Operational reporting and governance processes within Clinical Boards and corporate functions CP contributed to the discussion, highlighting that the organisation operated a highly devolved model, where accountability for policy implementation sat across multiple teams and service areas. She noted that, given the complexity, it may be more practical to focus on identifying and responding to instances of non-compliance, rather than attempting to centrally monitor compliance with all policies. CP suggested that the Committee may wish to give further consideration to how non-compliance was identified, escalated, and monitored, as that provided a more meaningful indicator of where policy frameworks may be failing in practice. **The Committee resolved that:** a) The contents of the report were noted.	
A&A 26/05/2.6	**Procurement Compliance Report (click to view)** CP presented the Procurement Compliance Report, positioning it as a routine but important element of the Committee's assurance framework, providing oversight of compliance with procurement processes across the Health Board. She began by contextualising the scale of procurement activity, noting that the organisation processes approximately 150,000 purchase orders annually, and that the instances of non-compliance reported should be considered within this broader operational context. CP highlighted that, following previous Committee feedback, the report had been enhanced to provide greater transparency and clarity, particularly in relation to the reasons for non-compliance and the actions taken in response. She explained that each instance was now more clearly categorised to distinguish between genuine non-compliance and justified exceptions, alongside a narrative explanation of the circumstances and the remedial action undertaken. This development was intended to strengthen assurance by moving beyond simple reporting of breaches to a more meaningful understanding of underlying causes and organisational learning. In presenting the data, CP noted that during the reporting period there had been 31 instances of non-compliant activity, alongside a number of contract breaches and exceptions. She emphasised that while those figures represented a relatively small proportion of overall procurement activity, they were taken seriously, and each case was subject to scrutiny to ensure appropriate corrective action was implemented. She further highlighted year-to-date figures indicating 133 non-compliant breaches and 70 approved exemptions, reinforcing the importance of maintaining vigilance and continuous improvement in procurement practices.	

	CP drew particular attention to the significant reduction in Single Tender Actions (STAs) and Single Quotation Actions (SQAs) compared to the previous year, describing it as a positive indicator of improved compliance and stronger procurement discipline across the organisation. She attributed the improvement to increased oversight, better engagement with procurement processes, and a more proactive approach from both procurement teams and service areas. This was presented as evidence that targeted interventions and governance scrutiny are having a tangible impact. The Committee explored the financial implications of non-compliance, with a member noting that the cumulative value of non-compliant transactions appeared significant. In response, CP provided important context, explaining that while non-compliance may suggest missed opportunities for cost savings, it did not necessarily equate directly to financial loss. She clarified that in many cases, expenditure would have occurred regardless, and that procurement involvement typically sought to optimise value rather than eliminate cost. She acknowledged that earlier engagement with procurement teams could potentially deliver marginal gains through negotiation but cautioned against assuming that all non-compliant activity would result in substantial savings if managed differently. CP emphasised that the focus of the procurement function was therefore not solely on compliance for its own sake, but on embedding a more strategic, lifecycle-based approach to procurement, particularly for high-value or long-term assets. She noted that some non-compliance arises from historic decisions, such as failure to secure maintenance arrangements at the point of initial purchase, which subsequently limits flexibility and creates reliance on single suppliers. Addressing that required a shift towards more forward-looking procurement planning and stronger integration of procurement considerations into service decision-making. Throughout the discussion, CP reinforced the importance of learning from each instance of non-compliance, describing each breach as an opportunity to improve processes and prevent recurrence. This included strengthening guidance, increasing awareness, and ensuring that procurement teams intervene at the earliest appropriate stage. Members acknowledged the progress made, particularly in reducing single tender actions, and recognised the importance of maintaining momentum in improving compliance while also ensuring a proportionate and pragmatic approach, given the scale and complexity of procurement activity across the organisation. **The Committee resolved that:** a) The contents of the report were noted and approved/agreed.	
A&A 26/05/3.1	**Committee Annual Report** The Committee Annual Report was received. **The Committee resolved that:** a) The contents of the report were noted. b) The report was endorsed to the Board for approval	
A&A 26/05/3.2	**Losses and Special Payments Panel Report 2025-2026**	

	Robert Mahoney (RM), Deputy Director of Finance presented the Losses and Special Payments Panel Report 2025/26 and provided an overview of the work undertaken by the Panel during the reporting period. He explained that the Panel met twice annually to review and approve losses and special payments across a range of categories, noting that the process involved a significant degree of scrutiny and assurance to ensure losses were minimised and appropriately accounted for. He further advised that the timing of the Panel meetings was closely aligned to the preparation of the Health Board's annual accounts and statutory financial returns. RM highlighted that bad debt write-offs had increased significantly during 2025/26 compared with previous years, largely due to charges incurred by overseas visitors who had required emergency treatment. He explained that a number of these patients had subsequently died, resulting in the associated debts becoming unrecoverable. He also drew attention to a small number of one-off debts, including an unpaid balance relating to the sale of an MRI scanner following the purchaser entering administration. The Committee was also informed of a number of stock write-offs during the year. RM advised that these primarily related to obsolete or expired stock identified through inventory reviews and the implementation of the Scan for Safety programme, together with stock management issues identified within a small number of departments. He noted that actions had been implemented within those areas to strengthen stock control processes and reduce the likelihood of recurrence. In addition, he reported on clinical negligence claims, explaining that whilst the gross value of claims remained significant, the majority of costs were recoverable through the Welsh Risk Pool. He advised that the Committee was being asked to approve the statutory write-off of these balances in accordance with accounting requirements. DE commented that the report was clear and welcomed the additional narrative which provided context to the figures presented. **The Committee resolved that:** A) The write offs for the period outlined in the Opinion and Key Issues Section of the report as recommended by the Losses and Special Payments Panels held on 11th November 2025 and 12th May 2026 were approved.	
A&A 26/5/4.1	**Annual Declarations of Interest Report** The Annual Declarations of Interest Report was received. **The Committee resolved that:** a) The contents of the report were noted.	
A&A 26/5/4.2	**Counter Fraud** The Counter Fraud Progress Update was received. The Counter Fraud Annual Plan 2025-27 was received. The Counter Fraud Annual Report 2025-26 was received. **The Committee resolved that:** a) The Counter Fraud Progress Updates were noted.	

A&A 26/05/6	**Any Other Business** No Other Business was discussed.	
A&A 26/05/7.1	**Items to be deferred to Board / Committee**	
A&A 26/05/7.2	**Date and time of next committee meeting** Tuesday 23 June (Special Meeting) via MS Teams.	

Minutes of the Special Meeting

Audit and Assurance Committee Public

Held on Tuesday 23.06.2026
Via MS Teams

To view the meeting, please click here: https://youtu.be/SBw8il7apsY
(please note, you may need to copy & paste the link into your browser)

Chair:		
David Edwards	DE	Committee Chair / Independent Member ICT
Present:		
Kirsty Williams	KW	UHB Chair
Ceri Phillips	CP	UHB Vice Chair
Clive Curtis	CC	Independent Member - Community
Suzanne Rankin	SR	Chief Executive Officer
Ian Virgil	IV	Head of Internal Audit
Rachel Gidman	RG	Executive Director of People & Culture
Frankie Ogden	FO	Head of Corporate Governance
Rachel Freitag	RF	Audit Manager – Audit Wales
Morgan Burchell	MB	Senior Auditor – Audit Wales
Catherine Phillips	CPH	Executive Director of Finance
Matt Phillips	MP	Director of Corporate Governance
Rob Mahoney	RM	Deputy Director of Finance
Helen Lawrence	HL	Assistant Director of Finance – Chief Financial Accountant.
Jayana Williams	JW	Senior Auditor – Audit Wales
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		

Item No	Agenda Item	
AACS 26/06/01	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AACS 26/06/01	**Apologies for Absence** Apologies for absence were noted. **The Committee resolved that:** a) Apologies were noted.	
AACS 26/06/002	**Declarations of Interest** No Declarations of Interest were noted.	
AACS 26/06/003	**Any other urgent business** There was no other urgent business noted.	

AACS 26/06/04.1	**The Head of Internal Audit Opinion & Annual Report for 2025-26 (click to view)** The Committee received the final Head of Internal Audit Opinion and Annual Report for 2025–26 from Ian Virgil (IV), Head of Internal Audit. It was noted that the overall opinion remained reasonable assurance, consistent with the draft opinion previously presented, with no change in the overall position. IV reported that, at the time of the draft opinion, five audits had still been in progress. Since then, four had been completed to at least draft report stage and were included within the overall audit work, bringing the total number of completed audits to 32. The outcomes of the audit programme were summarised, with the majority of reviews providing reasonable or substantial assurance, which supported the overall opinion. However, it was highlighted that there had been five limited assurance reports and one unsatisfactory report. These findings were acknowledged as key areas requiring management action and follow-up. It was confirmed that one limited assurance report and the unsatisfactory report were still in draft at the time of reporting. While the assurance ratings had been agreed, further work had been required to finalise management responses and assign actions. The Committee noted that it had not yet had the opportunity to review the full detail of the draft reports underpinning the opinion. It was confirmed that these would be presented to a future meeting on 1 September 2026 for formal scrutiny once finalised, although informal engagement between Internal Audit and Executive leads had already taken place. **The Committee resolved that:** a) The Head of Internal Audit Opinion and Annual Report for 2025-26 was considered and noted.	
AACS 26/06/4.2	**Introduction to Annual Report and Accounts 2025-26 (click to view)** The Committee received the final Annual Report and Accounts for 2025–26, together with the associated assurance and governance documents. It was noted that the draft accounts had been prepared and submitted to Welsh Government and Audit Wales at the beginning of May 2026, in line with the agreed timetable, and had since been subject to detailed audit review. Helen Lawrence (HL), Assistant Director of Finance Chief Financial Accountant reported that only a small number of amendments had been identified by Audit Wales, all of which had been incorporated into the final version. Those were largely	

	presentational or additional disclosure changes and did not alter the financial performance previously reported. The Committee was advised that Audit Wales intended to issue an unqualified true and fair opinion on the accounts, confirming that they were free from material misstatement and prepared in accordance with the relevant standards. However, a qualified regularity opinion would be issued, reflecting that the Health Board had breached its revenue financial duties over the three-year period, reporting a cumulative deficit. It was noted that the Health Board had met its capital resource limit. It was further noted that supporting assurance documents, including the letter of representation and responses to audit enquiries, had been provided to give assurance regarding the integrity of the accounts and the robustness of internal controls. The Committee acknowledged the significant work undertaken by Finance and Audit Wales in producing and scrutinising the accounts within challenging timescales, noting the high quality of the draft submission. While recognising the financial challenges highlighted, the Committee noted the overall positive audit outcome and agreed to recommend the Annual Report and Accounts, alongside the associated audit documents, to the Board for approval. **The Committee resolved that:** a) The reported financial performance contained within the Annual Report and Accounts was noted including that the UHB has not met its statutory financial duties in respect of revenue expenditure but had met its statutory financial duties in respect of capital expenditure. b) The changes made to the Draft Annual Report and Accounts were noted. c) The ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management, and the Annual Report and Accounts were reviewed. d) The ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management, and the Annual Report and Accounts were recommended to the Board for approval.	
AACS 26/06/4.3	**The CVUHB Annual Report 2025-2026 including the Annual Accountability Report, Performance report and the Financial Statements (click to view)** The Committee received an update on the final Annual Report narrative, following the draft version presented at the Audit Committee in May 2026. Matt Phillips (MP), Director of Corporate Governance noted that the report had been subject to further engagement with Audit Wales and Welsh Government since that time.	

	It was reported that only minor changes had been made to the report, primarily to provide additional clarity in relation to service reviews, limited assurance areas, and wellbeing objectives. Those amendments reflected further detail on points already included rather than any substantive changes to the content. The Committee noted that the report was being presented for recommendation to the Board for approval, rather than approval by the Committee itself. **The Committee resolved that:** a) The Annual Report & Accounts for 2025-2026 - Appendix 1were recommended for onward submission to the Board.	
AACS 26/06/6.1	**Any Other Business** No other business was discussed.	
	Date & time of next Meeting Tuesday 1 September 2026 – 9am via MS Teams	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update	Comments
AUDIT & ASSURANCE	Internal Audit Progress Report	A&A 26/02/2.1	Develop and bring back to a future meeting, thematic analysis (cross-Wales learning/themes) using the newly developed Audit & Assurance database shared with NHS Wales organisations.	Catherine Phillips	Ian Virgil	03/02/2026	19/05/2026	ON FORWARD PLAN	An initial analysis will be received at the 3rd September 2026 meeting.	On agenda for meeting held 01.09.2026
AUDIT & ASSURANCE	Internal Audit Progress Report - Quality & Safety Governance advisory review	A&A 26/02/2.1	Take a consolidated action plan to the Quality Committee, pulling together: Opportunities from the Internal Audit Quality & Safety Governance advisory review. Related actions from Audit Wales structured assessment and escalation framework work.	Jason Roberts, Emma Cooke, David Fluck	Jason Roberts	03/02/2026	01/09/2026	COMPLETE	The improvement plan was received by the Quality Committee in June 2026.	
AUDIT & ASSURANCE	Intneral Audit Progress Report	A&A 26/05/2.1	Review future May Audit & Assurance Committee meeting length/duration	Matt Phillips	Nathan Saunders	19/05/2026	01/09/2026	COMPLETE	Due to the concentration of year-end audit reports, further time has been allocated to the Internal Audit item for the May 2027 meeting.	

Report Title:	Internal Audit Progress Report			Agenda Item no.		2.1	
Meeting:	Audit & Assurance		Public	X	Meeting Date:	01/09/26	
			Private				
Status:	Assurance	X	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author:	Head of Internal Audit						

Main Report

Background and current situation:

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

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

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

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

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

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

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

The following reports that informed the 25/26 Opinion have been finalised since the May 26 meeting:

- Leadership & Management Training/Development (Reasonable Assurance)
- Five Steps to Safer Surgery (Reasonable Assurance)
- Medicines Management (Reasonable Assurance)
- Local / Shadow IT (Reasonable Assurance)
- Flexible Working Arrangements for Compressed and Variable Hours (Limited Assurance)
- Reducing Health Inequalities – Ethnicity Data (Unsatisfactory Assurance)
- Space Utilisation (Advisory)

The following reports informing the 26/27 Opinion have also been finalised since the May 26 meeting:

- Speaking Up Safely (Reasonable Assurance)
- ALAS Equipment Purchasing & Stock Management (Reasonable Assurance)
- Follow-ups Not Booked (From 25/26 plan) (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 proposed adjustments to the 2026/27 plan.

Recommendation:

The Audit & Assurance Committee are requested to:

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

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

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

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

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

Impact Assessment:

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

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

Safety: Yes/~~No~~

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

Financial: Yes/~~No~~

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

Workforce: Yes/~~No~~

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

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

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

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

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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee September 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

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

Audit	Current Position	Draft Rating	Reason
AI / Automation	Draft Report	Reasonable	Time taken to meet with all required contacts as part of the fieldwork.

3. Outcomes from Completed Audit Reviews

Seven audit reports from the 2025/26 plan were not finalised in time for submission to the Audit Committee in May 26, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2025/26. All of the reports have now been finalised, as detailed in the table below.

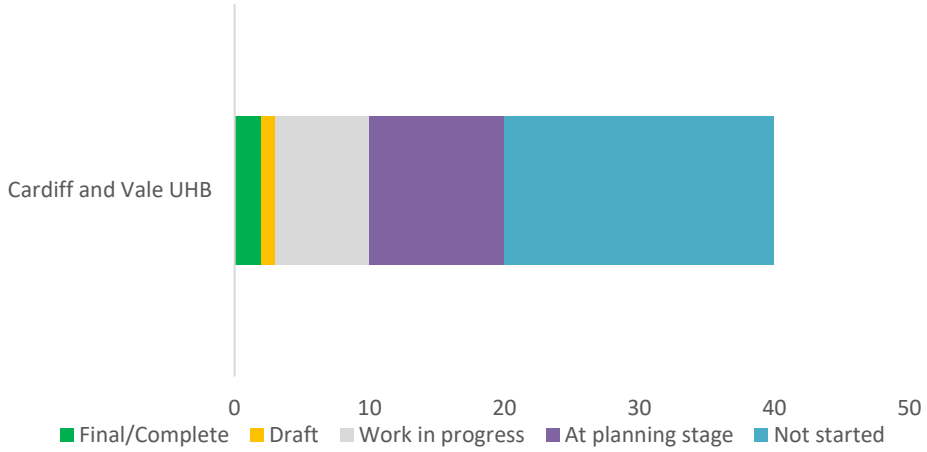
A further three assignments have been finalised since the previous meeting of the committee and are also highlighted in the table below along with the allocated assurance ratings.

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	
2025/26 Opinion		
Leadership & Management Training/Development	Reasonable	
Five Steps to Safer Surgery		
Medicines Management		
Local / Shadow IT		
Flexible Working Arrangements for Compressed and Variable Hours	Limited	
Reducing Health Inequalities – Ethnicity Data	Unsatisfactory	
Space Utilisation	Advisory	
2026/27 Opinion		
Speaking up Safely	Reasonable	
ALAS Equipment Purchasing & Stock Management		
Follow-ups Not Booked (From 25/26 plan)	Limited	

4. Delivery of the 2026/27 Internal Audit Plan

There is a total of 40 reviews within the 2026/27 Internal Audit Plan, (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that two 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 seven audits that are currently work in progress with a further ten 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:

- Clinical Safety Groups - Proposed for deferral to the 27/28 plan due to ongoing work to restructure the groups. Deferral is supported by the Executive Director of Nursing
- Charitable Funds - Proposed for deferral to the 27/28 plan due to recent staff changes and ongoing work to implement the new strategy. Deferral is supported by the Executive Director of Finance.
- Diabetes 8 Care Processes - Proposed for removal from the 26/27 plan due to overlap with the scope of the Audit Wales Diabetes Management review. Removal is supported by the Executive Director of Public Health.

The following audits have been identified to be added to the 26/27 plan:

- Flexible Working Arrangements Follow-up – The 25/26 report was finalised with Limited assurance after the 26/27 plan was approved.
- Neurodevelopment Services for Adults Follow-up – The 25/26 report was finalised with Limited assurance after the 26/27 plan was approved.
- Reducing Health Inequalities Follow-up – The 25/26 report was finalised with Unsatisfactory assurance after the 26/27 plan was approved.
- Grip & Control Self-Assessment – Proposed for addition to the 26/27 plan as the audit is being undertaken across all NHS Wales organisations. Addition is supported by the Director of Finance to replace the Charitable Funds audit.

The following audits of major capital projects have also been added to the 26/27 plan as part of the Approved Integrated Audit & Assurance Plans. The respective business cases for these projects, which include provision for Internal Audit review, have been agreed and funded by Welsh Government:

- Modernisation of Passenger Lifts: University Hospital Wales
- Pentyrch/Rhydlafar Branch Surgery
- Park View Health Centre

6. Final Report Summaries

6.1 Leadership & Management Training/Development

Reasonable Assurance

Purpose

Our audit of Leadership and Management Training / Development was completed as part of our 2025/26 Internal Audit workplan for Cardiff and Vale University Health Board (the 'Health Board'). The purpose of the audit was to review the ongoing work to deliver leadership and management training within the Health Board.

In 2023 we undertook an advisory audit of Leadership Management Training and Development (CVU-2324-10) and a number of opportunities for improvement and development were identified.

The People and Culture Plan 2022-2025 Theme 6 is 'Leadership and Succession' which details the Health Board's commitment to developing leaders and managers. The Health Board leadership approach requires a focus on inclusion, collaboration and authenticity.

The Health Board's Education, Culture and Organisational Development Department have developed a Sharepoint page which includes the leadership and management development programmes that are available, which are:

- First Steps to Leadership and Management – This is aimed at those who are developing a leadership and management role.
- Essential Leadership and Management Skills – This programme is for managers who are responsible for managing a team and deputy managers (band 6 upwards).
- Elev8 – (Clinical Managers Programme) – This is for Band 7 Clinical Managers.
- Initi8 – Deputy clinical managers programme. Band 6 aspiring clinical Managers.
- Coordin8 – Shift management programme for registered nurses taking charge of clinical area which includes Band 5/6s.
- Compassionate Leadership 1 x day course – All career employment groups at all levels.
- Optimising Operations (Operational Manager Programme) – This is for Operational Managers (8c) and is currently under development.

Overview

A 2026/27 Leadership and Management Framework is nearing completion, with approval expected in Summer 2026. Its finalisation depends on HEIW completing their own Competency Framework, which will be integrated into the Health Board (HB) training portfolio. The Framework aligns strategically with national leadership plans, the 2025/26 HB Annual Plan, the Board Assurance Framework (March 2026), and the HB's 'Brilliant Basics' principles. Our audit confirmed that resourcing of clinical and non-clinical training related to Leadership and Management Programmes is appropriately staffed to deliver the current provision, via the Education Team and Leadership and Management Team both of which sit within the Education Culture & Organisational Development (ECOD) team.

Health Board wide awareness of all Leadership and Management training offers is supported by a HB Leadership and Management Sharepoint site, a Viva site and via Communications Team emails.

All non-clinical and clinical Leadership and Management training Programmes have processes in place that provide monitoring and oversight of student attendance, course progress and completion and flexibility to change/retake course modules and transfer onto another course.

We also confirm that all Leadership and Management Programmes in place capture course participants feedback which is then reviewed and evaluated to amend and improve course content, quality and delivery where deemed appropriate.

We acknowledge that plans are in place to initiate reporting to the People and Culture Committee in the near future, but the Executive Director of People & Culture is appraised accordingly in this regard.

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

- Ensure ongoing engagement with the Clinical Boards to inform the development and finalisation of the Leadership and Management Framework.
- There is a need to continue to engage with Clinical Board Senior Management to promote awareness of Programmes.
- There was no reporting of training Programme progress delivery and outcomes to the People and Culture Committee.

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

- The draft Leadership and Management Framework needs to be updated to reflect the updated Health Board People and Culture Plan when its launched.

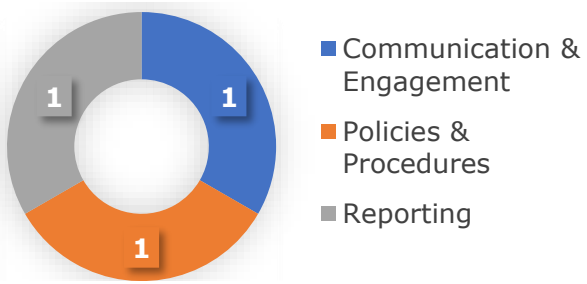
Scope & Assurance Summary

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 developed a Leadership Framework following engagement with staff and management identifying leadership and management training programmes that are available locally, nationally and UK wide	1	**Reasonable**
2	Suitable resources are in place to ensure adequate delivery of the Leadership and Management training programmes	-	**Substantial**
3	Staff and Managers are made aware of the Management and Leadership Programmes that are available	2	**Reasonable**
4	There are appropriate completion rates of the programmes and attendees are requested to provide user feedback	-	**Substantial**
5	The Leadership and Management Programmes are appropriately evaluated to ensure their aims and objectives are achieved	-	**Substantial**
6	There is adequate monitoring and progress reporting on the leadership and management training activity to the People and Culture Committee and Board	3	**Reasonable**

Management Actions

0	3
High Priority	Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

6.2 Five Steps to Safer Surgery

Reasonable Assurance

Purpose

The audit was to establish if effective arrangements are in place to ensure all stages of the World Health Organisation (WHO) five steps to safer surgery checklist are consistently undertaken.

The World Health Organisation (WHO) Checklist for safer surgery involves a team based approach with five key steps:

- Briefing – to confirm the order of the operating list, to delegate tasks and to confirm that everyone knows their role during the procedure and support necessary preparations;
- Sign-in – to ensure all necessary preparations for surgery have been made and that it is safe to proceed with the operation;
- Time Out – to ensure that the surgical team is undertaking the correct procedure on the correct patient, and that all the correct measures are in place to prevent harm;
- Sign Out – to ensure that the surgical procedure has been completed in its entirety and documented accordingly; and
- Debriefing – to allow the surgical team to review their performance, to identify achievements along with any areas that may need improvement.

We previously undertook an audit of the Five Steps to Safer Surgery in 2021/22 with a 'Limited Assurance' rating. We undertook a follow-up review in 2022/23 and a 'Substantial Assurance' rating was provided as all actions were implemented.

The Health Board carried out an internal review of Theatres at the University Hospital Wales and there were six recommendations that required immediate attention including 'Audit adherence to policies and procedures for consent and 'WHO Checklist', ensure standardised application across all theatres and provide update training as required.'

Before the review had been published a WHO checklist safety collaborative initiative had been commenced, led by the Surgery Clinical Board Clinical Director and Director of Nursing. Since the review the organisation has reaffirmed its zero tolerance to non-compliance with the WHO safety check lists and reset its expectations regarding the 5 key steps.

Overview

We have concluded **reasonable** assurance on this area. During the audit we were able to verify that the checks were being completed, however, we evidenced some inconsistencies in recording signatures within the Theatre care plans. There are further plans already in place around adding the team briefing onto whiteboards and in the longer term digitally recording all five steps on the Aqua Theatre man System. The following matters were identified during our audit that require management attention:

- Many of the Perioperative Directorates Policies and Procedures including 5 Steps to Safer Surgery Procedure were out of date;
- There was a lack of awareness and staff 'buy-in' for the planned installation of team briefing whiteboards;
- Not all staff were present for the Team Briefing and Sign-out stages for the surgeries observed;
- The WHO checklists within theatre care plans were not always being fully completed and signed off at each stage; and
- There is no timescale for the implementation of the WHO checklist within the Aqua Theatre man system.

Scope & Assurance Summary

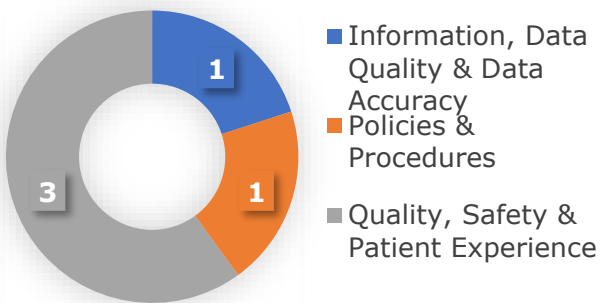
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Effective governance arrangements are in place which ensure the implementation of the Five Steps to Safer Surgery including appropriate procedures.	1	**Reasonable**
2	Systems and processes are in place at an operational level, on a day-to-day basis which ensure that all stages within the Five Steps to Safer Surgery are being undertaken throughout the Health Board.	2, 3, 4	**Limited**
3	Monitoring and reporting processes are in place which provide adequate and timely assurance that the Five Steps to Safer Surgery are being utilised effectively and on a consistent basis throughout the Health Board.	5	**Reasonable**

Management Actions

2 High Priority

3 Medium Priority

Themes



Risk Types

Quality or Safety Issues

6.3 Medicines Management

Reasonable Assurance

Purpose

Our review of Medicines Management was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board ('the Health Board')

The purpose of the audit was to review Medicines Management arrangements following introduction of the electronic system, including a focus on medication safety and management of risks.

The Health Board has produced a Medicines Code to replace previous Medicines Policies and Procedures. The purpose of the Medicines Code is to set out a clinical and corporate governance framework to promote safe and secure systems for the controlling and handling of medicinal products in hospitals and clinics operated by the Health Board.

The Health Board are in the process of implementing an Electronic Prescribing and Medicines Administration (ePMA) system to enable more efficient medication management. The new system will allow healthcare professionals to electronically prescribe and administer medicines.

As part of the audit, we visited and undertook fieldwork in wards B4 and Lakeside 4 in University Hospital of Wales (UHW) and East 2 and Ash in University Hospital Llandough (UHL).

Overview

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

- Medicines management training is not consistently completed.
- The ePMA tap to order function may result in duplicate orders, as ward staff may be unaware that an order has already been placed, leading to repeat orders that subsequently require cancellation.
- All staff should be reminded of the required medicines storage arrangements and the importance of adhering to these to prevent lapses in compliance.
- A small number of medicines related incidents and risks had remained open within the Datix system for an extended period without adequate investigation and follow up having been undertaken.

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

- The Medicines Code on the intranet policies page is not the latest version, although it is not vastly different.
- There have occasionally been difficulties getting ePMA QR codes to scan successfully which will need to be kept under review.
- The introduction of notifications to medicines administrators when changes are made to a patient's prescription would be beneficial, as this would allow sufficient time to obtain medicines where required.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Appropriate and up to date written Medicines Management policies/procedures are in place, including detail on the new electronic system, which have been communicated to all staff required to follow them.	-	**Substantial**
2	Relevant staff have received appropriate training on the medicines management processes, including the new electronic system.	1	**Reasonable**
3	The written policies/procedures are being followed correctly within wards and departments and ensure that medicines are being prescribed, ordered, received, stored and administered appropriately in line with pharmacy standards, Health & Safety requirements and other relevant regulations.	2, 3	**Reasonable**
4	Medicines Management audits are being carried out by wards as part of the routine Tendable audit process.	-	**Substantial**
5	Robust processes are in place for the identification, recording and reporting of Medicines management related incidents and risks and mitigating actions and learning are implemented to prevent recurrence.	4	**Reasonable**

Management Actions

2 High Priority

2 Medium Priority

Themes

Risk Types

Quality or Safety Issues

6.4 Local / Shadow IT

Reasonable Assurance

Purpose

To review the processes and guidance in place within the Health Board's Digital team for ensuring appropriate professional oversight of locally managed IT systems to ensure they comply with best practice.

Overview

We have concluded **reasonable** assurance on this area. There is guidance in place, provided by Digital & Health Intelligence (D&HI or 'Digital') over how digital items and Information Governance should be managed, although we note that much is out of date. There is a Committee with formal responsibility for Digital which demonstrates oversight, particularly over D&HI controlled aspects. There are good relations between Procurement and D&HI which facilitates the identification of new items and there are very good technical controls in place to protect the Health Board. We note that there is no full record of digital items across the Health Board and as such no full evaluation of the risk that this presents.

The matters requiring management attention include:

- Although there is a range of guidance in place for the management of digital items, information governance and security, much of this is out of date and requires reviewing and updating. We also note that there is currently a lack of a succinct summary of requirements for managing digital systems and contracts available to relevant staff.
- As noted in our previous report on Cyber Security there is a feed into the wider organisation from the Digital and Infrastructure Committee (DIC), however there is no representation from Clinical Boards and the Chief Operating Officer does not attend, as such there is limited visibility and accountability over how devolved digital items are managed and overseen.
- We noted a number of suppliers without a cyber essentials certification, including the supplier of the Dental system which has been recently upgraded. The specification for this did not include a Cyber Essentials (CE+) requirement and our discussion with Procurement noted that the inclusion of this is reliant on Digital input and not a standard requirement within specifications for applications.
- There is no complete, accurate record of what digital systems and suppliers are in use across the whole organisation and no assessment of criticality, no completion of CAF assessments outside of D&HI and no assessment of the risk that suppliers present.
- There is a wide range of software in use, with some breaching Health Board Policy and Welsh Government requirements. Despite management of these being devolved, these risks are not being recorded within departmental risk registers and so the true risk to the Health Board is unquantified.

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

- D&HI should consider using the reporting functionality from the firewalls to identify medical devices that present a risk to the Health Board.
- D&HI should consider using the SCCM reporting function to populate their records and focus on high risk areas.

Scope & Assurance Summary

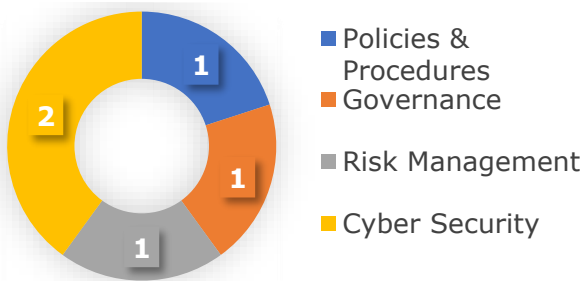
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	IT systems and digital tools procured or managed outside the central IT function are required to comply with relevant digital policies, procedures and guidance and are included within the overall digital governance and oversight arrangements.	1, 2	**Reasonable**
2	Procurement and contract management processes prevent unauthorised or duplicate IT systems from being acquired and supported outside of digital services oversight.	3	**Reasonable**
3	Controls are in place to prevent users from downloading and installing software without explicit approval.	-	**Substantial**
4	Processes are in place to identify shadow IT and ensure risks are managed appropriately (cyber-security, compliance).	4, 5	**Limited**

Management Actions

3 High Priority

2 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

6.5 Flexible Working Arrangements for Compressed and Variable Hours

Limited Assurance

Purpose

The audit of Flexible Working Arrangements for Compressed and Variable Hours was completed as an addition to the 2025/26 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board'), following a request from the Chief Operating Officer. The purpose of the audit was to review the process for how flexible working arrangements relating to compressed hours were agreed, reviewed and worked and how annual leave was managed for those working compressed hours.

Overview

Flexible working benefits individuals in enabling them to balance their personal life with their working life. In addition, it benefits the Health Board as employees can be retained and therefore experienced and skilled staff are maintained.

The Health Board has formally adopted the All Wales Flexible Working Policy which reflects the NHS Wales commitment to promoting a flexible working culture. Under this policy, employees can formally request flexible working arrangements.

Requests to working flexibly should be undertaken by completing a Flexible Working Request Form or completing the request on ESR and submitting to the Line Manager. The Manager must meet with the employee to discuss the flexible working request, consider its feasibility, and confirm whether it is approved. Each department is responsible for maintaining records of all formal applications for Flexible Working including approvals and rejections.

There are many types of flexible working which employees may apply for, and as part of this audit we focussed on compressed hours, whereby employees work their full contracted hours over a shorter period than is standard. Staff working compressed hours must ensure they correctly record their actual contracted hours when requesting annual leave or bank holidays, rather than assuming a standard 7.5 hour day. In addition, we also be focussed on variable hours whereby staff work varying patterns. The audit was carried out in the Medicine Clinical Board.

We have concluded **limited** assurance on this area. Overall, there is limited awareness and inconsistent application of the Flexible Working Policy and Annual Leave Procedure. Required processes, including the completion of Flexible Working Request forms and ESR submissions, are not being consistently followed. In addition, managers are not consistently monitoring staff working patterns—partly due to limited use of HealthRoster—resulting in discrepancies where annual leave and bank holiday requests do not always align with employees' contracted hours. The significant matters requiring management attention include:

- Limited awareness of the Flexible Working Policy was identified through our testing, as there was evidence that Flexible Working Request forms or ESR requests had not been completed for some staff working compressed or variable hours.
- Limited awareness of the Annual Leave Procedure was evident, with staff working compressed or variable hours not consistently requesting annual leave or bank holidays based on their contracted hours.
- Flexible Working Request forms were not completed in accordance with the requirements set out in the Flexible Working Policy.
- ESR requests for flexible working were also not submitted in line with the Flexible Working Policy.
- Managers were not consistently monitoring staff working days and hours, with this issue compounded by the lack of Healthroster utilisation.

- Annual leave requests did not always reflect employees' contracted hours.
- Bank holiday requests were not always aligned with employees contracted hours.

Scope & Assurance Summary

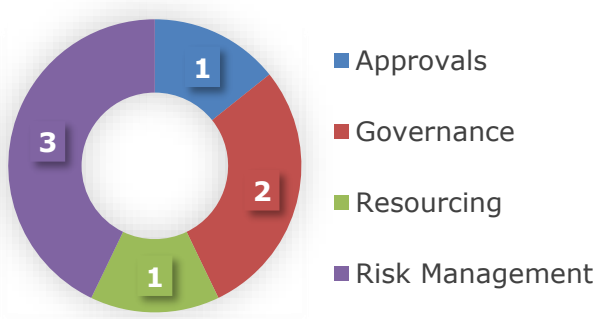
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate and up to date policies and procedures covering flexible working arrangements are in place, including management of compressed hours and of annual leave and these are readily available to all management and staff	1,2	**Reasonable**
2	A formal documented and/ or evidenced request is recorded in ESR for all staff working compressed hours and variable working patterns	3,4	**Limited**
3	Effective processes are in place for the ongoing monitoring and review of staff working compressed hours and variable working patterns to ensure approved days and hours are being worked	5	**Reasonable**
4	Annual leave and banks holidays for staff working compressed hours and variable working patterns are being effectively managed to ensure correct hours are taken and annual entitlements are not exceeded	6,7	**Limited**

Management Actions

4 High Priority

3 Medium Priority

Themes



Risk Types

Financial Loss

6.6 Reducing Health Inequalities – Ethnicity Data

Unsatisfactory Assurance

Purpose

The review of Reducing Health Inequalities was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board (the Health Board). The purpose was to review the processes for collecting ethnicity data within primary and secondary care, and how the data is being utilised to identify and reduce health inequalities.

The general duty of the Equality Act 2010 sets out that those subject to the duty must have regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

NHS Wales is required by the Equality Act 2010 to collect patient data related to the six protected characteristics to meet the Public Sector Equality Duty which includes age, disability, race, religion or belief, sex and sexual orientation.

Health Inequity is a Strategic Risk detailed on the Health Board's Board Assurance Framework (BAF) and one of the actions to address the risk is to 'improve the routine data collection in relation to equality and inequity across the UHB.' It was agreed with the Executive Director of Public Health that the current audit would focus on reviewing the processes for the collection of ethnicity data within the Health Board.

Overview

We have concluded **unsatisfactory** assurance on this area. There are fundamental weaknesses with the Health Board's governance arrangements, data quality processes and utilisation of ethnicity data which significantly limit the organisation's ability to demonstrate progress against its equality objectives or provide assurance to the Board. Collectively, these issues present significant risks relating to regulatory compliance, service quality and reputational impact.

The significant matters requiring management attention include:

- There is no organisation wide register identifying systems that collect patient ethnicity data.
- Staff have not been provided with formal training or guidance on collecting patient ethnicity data.
- There is no established quality assurance framework to ensure the accuracy and completeness of ethnicity data.
- Clear ownership and accountability for ethnicity data collection has not been established.
- Ethnicity data is stored in fragmented, siloed systems, limiting its effective use for strategic analysis and decision making.
- Ethnicity data is not embedded within the governance structure, resulting in limited oversight and assurance.

Scope & Assurance Summary

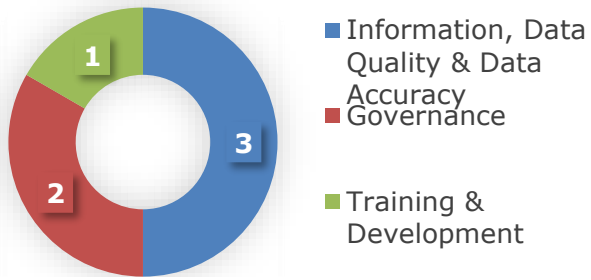
Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Appropriate arrangements, procedures and systems are in place within the Health Board to enable the effective collection of ethnicity data	1,2,	**Limited**
2	There are adequate quality assurance checks to ensure that data collected is complete and accurate	3	**Unsatisfactory**
3	Effective processes are in place to ensure effective utilisation and reporting of the ethnicity data within the Health Board	4,5,6	**Unsatisfactory**

Management Actions

5 High Priority

1 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

6.7 Space Utilisation

Advisory

Purpose

Optimising space utilisation within NHS Wales is crucial to support improved efficiency, cost reductions and to benefit patient care.

This advisory review sought to evaluate the effectiveness of the management and control of space utilisation within the University Health Board (UHB), share learning across NHS Wales organisations at which this review is taking place, and where possible provide best practice guidance and suggested opportunities for improvement.

The review originated from the 2025/26 internal audit plan, agreed with management, and approved by the Audit Committee.

Overview

The UHB arrangements for managing space utilisation were found to be less mature than those observed in some other NHS Wales organisations. More broadly, NHS Wales remains less advanced than NHS England in terms of the availability of estate data and the maturity of processes used to optimise space utilisation.

Whilst limited data was available within the UHB with which to assess space utilisation and performance against the baseline metrics set out in the Estates Strategy (2018-2028), available headline estate-wide measures indicate the aims of the Strategy have not yet been achieved.

The Estates Strategy, and space utilisation data contained within, is now significantly out of date, but we recognise the challenges in updating this in the absence of an approved clinical services plan. Any update also requires detailed up to date estate condition and utilisation data. We note significant progress in these areas in recent months, with the Clinical Services Plan approved by the Board in March 2026 and Estate Condition surveys recently concluded, both of which will support the UHB in moving forward with an update to the Estates Strategy. The ongoing extensive Community Assets Review aims to map and understand the use of UHB-owned assets in the community, and the services provided within them, to provide a baseline to shape an updated Estates Strategy.

Noting the significant level of backlog maintenance costs identified within the UHB, and continuing pressure on limited Welsh Government capital funds, the UHB, along with the rest of NHS Wales, should aim to prioritise increased understanding of space utilisation to drive strategic planning and improved utilisation of the existing estate going forward. The scale of the challenge ahead is recognised, noting the size of the estate and relatively limited progress made to date in obtaining utilisation data.

Noting the advisory nature of the review, we have not provided assurance ratings or recommendations but have identified several areas for management consideration.

Scope & Assurance Summary

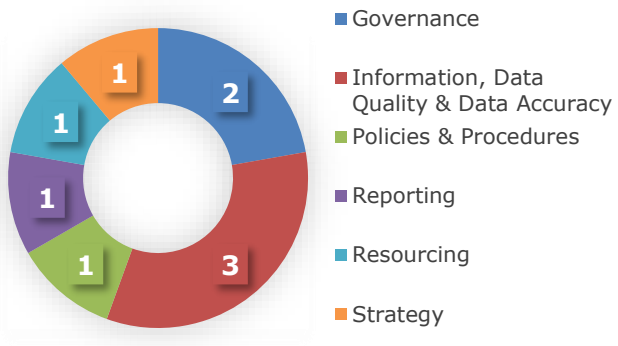
	Objectives	Related Considerations
1	**Strategy and Governance:** To consider whether the UHB's strategy for space utilisation across its estate is adequately defined and approved. That measurable targets and objectives have been established for the short, medium and long term. That there are supporting policies and procedures in place. That appropriate governance arrangements have been defined and are operating effectively.	1-4
2	**Data Capture and Monitoring:** That a robust baseline for space occupancy and associated costs has been established, together with robust ongoing monitoring mechanisms. Processes are in place for the ongoing monitoring of space utilisation, to provide up to date data to enable monitoring against performance targets, inform decisions, e.g. via surveys, audits, monitoring software etc. Demonstration that evaluation data is collated from post-completion project reviews to confirm whether new build spaces are being utilised in accordance with the agreed business case objectives. Assess the utilisation of monitoring tools to track space utilisation.	5,6
3	**Management and Compliance:** Review processes and technological tools for managing space utilisation, including compliance with policies and procedures for space allocation, changes in use, surplus space management, and decision-	7,8

	making around leasing/SLAs to enable optimisation of space. Evaluate the integration of cost considerations in decisions and the assessment of available space in project planning stages.	
4	**Performance Evaluation and Reporting:** Assess how space utilisation data is used to monitor performance against established targets. Assess how data informs strategic planning for the estate. Evaluate the effectiveness of reporting mechanisms, including actions taken to address under-utilisation.	9

Management Considerations

9

Themes



Risk Types

Financial Loss

Quality or Safety Issues

Public Perception & Reputational Risk

6.8 Speaking Up Safely

Reasonable Assurance

Purpose

Our audit of Speaking Up Safely (SUS) was completed as part of our 2026/27 Internal Audit work for Cardiff and Vale University Health Board (the 'Health Board'). The purpose of the audit was to review the effectiveness and operation of the Health Board's processes for speaking up safely and the raising of staff concerns, including the level and awareness of these processes across the Health Board.

The NHS Wales Speaking Up Safely Framework (WHC/2023/036), issued by Welsh Government in September 2023, states that '*this is the Framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised'*.

Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, the public and the NHS workforce, as well as helping to improve the population's experience of healthcare.

Overview

The Health Board has a current Speaking Up Safely (SUS) Guidance document that is aligned to the Welsh Government SUS Framework and clearly sets out how concerns can be raised. This includes multiple reporting routes such as email, telephone, and the confidential Work in Confidence (WIC) reporting platform, which supports anonymous reporting and structured case management.

Since the launch of SUS in December 2024, the Health Board has undertaken extensive awareness activity to embed SUS culture and promote the WIC reporting platform. This includes ward-based engagement, leadership communications, training and induction programmes, and awareness sessions for Board members. The implementation of SUS is supported by dedicated resources, funding for the WIC reporting platform, and the ongoing recruitment of volunteer SUS Connectors, helping to integrate SUS into wider workforce development.

Our sample based testing indicates that concerns raised through SUS are managed effectively and in line with Welsh Government Framework requirements. Cases are acknowledged promptly, progressed within expected timescales, and include appropriate consideration of staff welfare and escalation where required. Overall, this reflects a well-developed system with consistent processes, governance, and monitoring arrangements, including annual oversight by the People and Culture Committee through SUS reporting.

SUS Connectors play a key role as impartial staff volunteers, offering initial advice and directing individuals to appropriate resolution pathways without acting in a managerial or advocacy capacity. They are supported through training, guidance, system access, and ongoing engagement via internal forums, enabling knowledge sharing and consistent practice.

We have concluded **reasonable** assurance on this area, the matters requiring management attention include:

- The Health Board's staff SUS Guidance document does not include the Welsh Government SUS Framework compliance timescales and is not available in the Welsh Language.
- The Health Board has not established a planned ongoing SUS awareness programme.

- There was a lack of Speaking Up Safely Connectors representation across some areas within the Health Board.
- There was minimal uptake of ESR SUS Training modules by staff and managers.

Scope & Assurance Summary

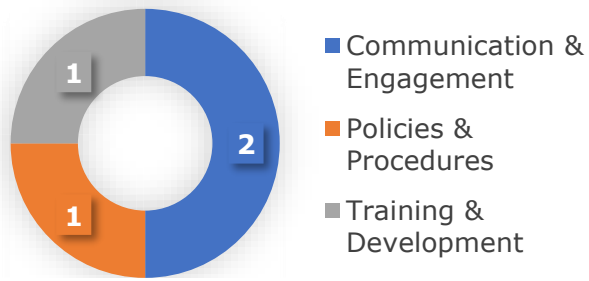
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The process for staff to raise concerns is appropriate and is clearly documented and subject to regular review.	1	**Reasonable**
2	Arrangements are in place to raise staff awareness of the process for speaking up safely, ensuring they can do so with confidence and that they will be supported and not suffer detriment as a result. The process for managing concerns once raised is effective and consistently adhered to.	2, 3	**Reasonable**
3	Designated contacts, responsible for the handling of staff concerns are aware of their responsibilities and have received training to deal with the concerns appropriately.	4	**Reasonable**
4	Regular updates are provided to the Board or relevant committee on the implementation of the Welsh Government framework and the ongoing operation of the SUS processes, and any lessons learnt to date are shared.	-	**Substantial**

Management Actions

0 High Priority

4 Medium Priority

Themes



Risk Types

Quality or Safety Issues

6.9 ALAS Equipment Purchasing & Stock Management

Reasonable Assurance

Purpose

Our review of ALAS – Equipment Purchasing and Stock Management was completed in line with the 2026/27 Internal Audit Plan for Cardiff and Vale University Health Board ('Health Board'). The purpose of the audit was to review the processes within the Artificial Limb and Appliance Service (ALAS) for the purchasing of equipment and management of stock.

The Artificial Limb and Appliance Service (ALAS) is a specialist, multidisciplinary service within Cardiff and Vale University Health Board providing assessment, treatment, and ongoing support for individuals with limb loss, limb difference, and a wide range of complex physical, rehabilitation, and rehabilitation-related needs.

ALAS delivers care across multiple service areas, supporting patients throughout Wales (Some services cover All Wales some cover just the Health Board). The service brings together clinical, technical, and operational teams to provide safe, effective, and patient-centred care, with a focus on maximising independence, mobility, and quality of life. Core Service Areas:

- Prosthetics (SE Wales): Assessment, design, fitting, and ongoing review of artificial limbs for patients with limb loss or limb difference.
- Orthotics (Mostly Cardiff & Vale – however for hospital based care this may cover surrounding areas): Supply and management of orthotic devices such as braces, specialist footwear, and mobility aids to support physical function and alignment.
- EAT (Electronic Assistive Technology) (All Wales): Provision and support of assistive technology solutions to enhance independence, communication, and environmental control for patients with complex needs.
- Wheelchair and Posture (PMC) (South and Mid Wales – Specialist Seating covering SE Wales): Assessment, prescription, provision, and maintenance of wheelchairs, seating, and posture management equipment to support mobility, comfort, and long-term health outcomes.
- Artificial Eyes Service (All Wales): Specialist provision, fitting, and ongoing review of artificial eyes, including cosmetic and functional support for patients.

However, the scope of our review was restricted to Wheelchair and Posture (PMC).

Overview

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

- The analysis of average lead time by supplier report included multiple error messages.
- There are delays in handing over equipment to patients due to clinician resource capacity constraints.
- At the time of fieldwork the ALAS stock management system "BEST" included 37 orders which had been open for 6 weeks or more.
- A mechanism should be developed to summarise the weekly stock count variances.
- Physical movements of stock are not always recorded within BEST.

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

- Development of formal standard operating procedures will improve on the basic work instructions which are currently in place.

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	Clearly documented procedures are in place for the ordering of equipment and appliances following patient assessment, and these ensure that all purchases are justified, timely and placed with appropriate suppliers.	1, 2, 3	**Reasonable**
2	There are adequate controls over non-catalogue spend so that value for money is achieved whilst quality/supply problems are avoided.	-	**Substantial**
3	All stock is accurately recorded, stock movements are appropriate and authorised, and regular stock counts are undertaken and discrepancies investigated.	4, 5	**Reasonable**
4	Stock levels are effectively managed to balance availability with minimising overstocking and waste.	-	**Substantial**
5	Periodic monitoring of the purchasing and stock management processes is undertaken and issues identified are appropriately reported and addressed.	-	**Substantial**

Management Actions

0 High Priority

5 Medium Priority

Themes

Risk Types

Quality or Safety Issues

6.10 Follow-ups Not Booked

Limited Assurance

Purpose

Our review of the Follow Ups Not Booked (FUNB) was completed in line with the 2025/26 Internal Audit Plan for the Cardiff and Vale University Health Board ('the Health Board'). The purpose of the audit has been to review the Health Board's processes in place to manage patient follow-ups and identify and address patients who have been lost to the follow-up process, in order to minimise the risk of harm.

Follow-up appointments relate to patients whose health is monitored over time after treatment or initial contact. Timely follow up appointments are required to ensure patient safety, continuity of care and the monitoring of patient progress.

Overview

We have concluded **limited** assurance on this area. While systems, processes, and governance structures exist in principle, they are not consistently applied in practice and do not operate effectively to ensure follow-up patients are identified, monitored, and progressed in a timely manner. Key weaknesses were identified in the lack of standardised processes, the reactive management of follow-up pathways, and inaccurate and incomplete data, which collectively undermine the reliability of reporting and the ability to manage patient risk. The significant matters requiring management attention include:

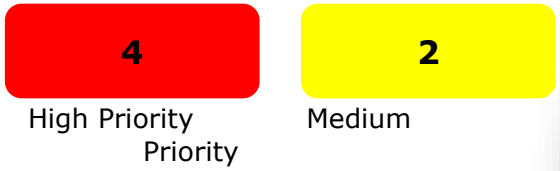
- There is no up-to-date Health Board-wide Standard Operating Procedure for managing follow-ups, leading to inconsistent practices across services.
- Follow-up patients are managed reactively, with limited routine monitoring and no consistent proactive oversight.
- Clinic outcomes are not consistently recorded, resulting in delays, missed follow-ups, and inaccurate patient records.
- Follow-up data is inaccurate and misleading, with significant numbers of invalid pathways and missing target dates.
- Follow-up pathways are not routinely monitored within governance forums, which remain focused on RTT performance.
- Board-level reporting does not provide a full view of follow-up demand, limiting visibility of risks.

Scope & Assurance Summary

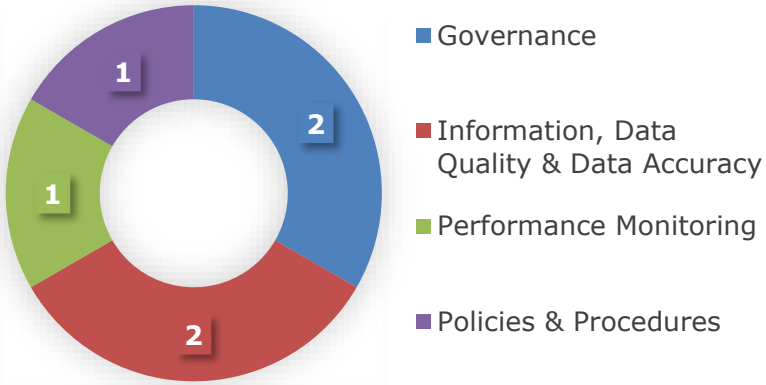
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Health Board has appropriate structures and processes in place to manage patient follow-ups within the Clinical Boards and Directorates complying with national Referral To Treatment (RTT) guidelines.	1,2 and 3	**Limited**
2	The Clinical Boards and Directorates 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 or patients have been lost to the follow-up process.	3,4 and 6	**Limited**

3	The Health Board has developed appropriate data to capture the management of patient follow-ups, including measures such as the timeliness of patients being seen; and	3,4 and 6	**Reasonable**
4	The delivery of patient follow-ups within adequate timeframes is effectively monitored by Clinical Boards, with assurance provided to the Board and appropriate Committees, and where performance issues are identified, appropriate rectifying action is undertaken.	2,5 and 6	**Limited**

Management Actions



Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
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		Draft Report	Reasonable	November
Audiology Referral and Waiting List Management	32	Therapies and Health Sciences	1		Fieldwork		November
Infection Prevention and Control	18	Nursing	~~3~~	2	Fieldwork		November
CD&T CB Governance Arrangements	21	Chief Operating Officer	2		Fieldwork		November
Medicine CB - Governance Arrangements	22	Chief Operating Officer	~~3~~	2	Fieldwork		November
Development of the Clinical Services Plan	35	Strategy, Planning and Partnerships	1/2		Fieldwork		November
Escalation Status Governance / Actions	04	Strategy, Planning and Partnerships / Finance	2/3		Fieldwork		November
CB Adherence to the Managing Attendance at Work Policy Follow up	08	People & Culture	2		Final brief issued		November
Budget Setting	05	Finance	2		Fieldwork		November

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Cyber Security Follow up	27	Digital & Health Intelligence	~~TBC~~	2	Final brief issued		November
INNU follow-up	15	Medical	~~TBC~~	2	Planning		November
Clinical Audit	14	Medical	~~2/3~~	3	Planning		February
Endoscopy	24	Corporate Governance	~~1/2~~	3	Final brief issued		February
Telecoms	29	Digital & Health Intelligence	2/3		Final brief issued		February
Staff Rostering	10	People & Culture / Relevant Staff Group Executives	~~1/2~~	3	Final brief issued		February
Strategic planning Infrastructure	36	Strategy, Planning and Partnerships	3/4		Draft brief issued		February
Regulatory and Legislative Compliance	03	Corporate Governance	2				February
People & Culture Strategic Development	12	People & Culture	3				February
Nationally Reportable Incidents (NRIs)	19	Nursing	2/3				February
Radiology Staff Rotas	23	Chief Operating Officer / Therapies and Health Sciences	~~1~~	3			February
Digital Systems Uptake and Utilisation	30	Digital & Health Intelligence	3				February
Flexible Working Arrangements for Compressed and Variable Hours Follow-up	40	COO / People & Culture	~~TBC~~	3			February
Grip & Control Arrangements – Self Assessment Review	41	Finance	3				February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Workforce Planning	11	People & Culture	3				May
Planned Care	25	Chief Operating Officer	~~2/3~~	3			May
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
Tracking of improvements following reviews	33	Chief Executive	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		Final brief issued		November
Pentyrch/Rhydlafar Branch Surgery	38	Finance	3		Final brief issued		February
Park View Health Centre	39	Finance	TBC				TBC

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
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. To be agreed by September 26 AC.				
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. To be 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. To be agreed by September 26 AC.				

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
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

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	G	75% 3 from 4	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 3 from 3	95%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	67% 2 from 3	85%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 3 from 3	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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Report Title:	Internal Audit Thematic Review			Agenda Item no.	2.2		
Meeting:	Audit & Assurance	Public	X	Meeting Date:	01/09/26		
		Private					
Status:	Assurance	X	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author:	Head of Internal Audit						

Main Report

Background and current situation:

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

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

The 'Internal Audit Thematic Review' presentation has been created from the database utilising the Power BI report and provides information on the Cardiff and Vale Internal Audit work completed over the last 6 years.

The following is a brief summary of the information provided within each slide. Further analyses and explanations will be provided as part of the presentation:

Slide 1 – Introduction slide.

Slide 2 - Gives an overall view of the total volume of Internal Audit work completed for Cardiff and Vale over the last 6 years. It identifies the numbers of audits completed each year and the outcomes across the 5 assurance ratings per year, and the trend of the ratings over the period.

Slide 3 – Identifies the assurance breakdown across the 6 years for Cardiff and Vale and provides the same information for all the Health Boards in Wales as a comparison.

Slide 4 - The Internal Audit plan is structured around 8 domains. This slide analyses the assurance ratings provided for the audits completed within each of the domains across the 6 years. It also provides the comparative information for all the Health Boards.

Slide 5 - Gives details of the findings we have identified as part of all the audits completed over the 6 years. This analyses the finding's priority ratings and whether they are design or operation in nature.

Slide 6 – Each of the findings we raise is allocated to a specific theme. There is a total of 18 themes, and this slide identifies the percentage of findings allocated across the top 10 themes for Cardiff and Vale for the period 23/24 to 25/26.

Slide 7 – Identifies the percentage of findings allocated across the top 10 themes for all Health Boards for the period 23/24 to 25/26 to date.

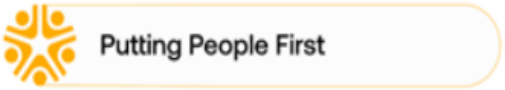
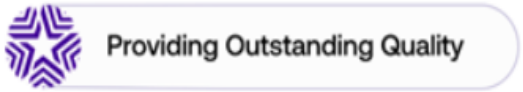
Slides 8 & 9 – Provide some examples of the findings included within the 2 top themes for Cardiff.

Slides 10 & 11 – Confirm what the definitions are for each of the top 10 themes.

Slide 12 – Summarises the key observations for further consideration, as noted from the review of the database.

Executive Director Opinion and Key Issues to bring to the attention of the Committee:
The slides within the presentation provide an analysis of the trends and themes identified through the internal audit work that has been completed for the Health Board, along with a comparison to those identified through the work completed for all Health Boards within Wales. This includes details of the assurance ratings provided for all the audits completed over the period, the key findings identified as part of the audits and the themes associated with the findings. The presentation is intended to highlight the key trends and themes identified through the previous Internal Audit work, in order to inform thinking around potential areas of future focus for both the Committee and Internal Audit.

Recommendation:
The Audit & Assurance Committee are requested to: • **Consider** the trends and themes highlighted through the analysis of the outcomes of previous Internal Audit work.

Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
 1. **Click the objective above to view more detail.**		 2. **Click the objective above to view more detail.**	
 3. **Click the objective above to view more detail.**		 4. **Click the objective above to view more detail.**	

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

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

Impact Assessment:
Risk: Yes/~~No~~ (delete as appropriate)
The presentation includes information from all audits undertaken for the Health Board over the last 6 years. These will have provided assurance around controls and processes relating to Risk and all of the other areas. below.
Safety: Yes/~~No~~
Financial: Yes/~~No~~
Workforce: Yes/~~No~~
Legal: Yes/~~No~~
Reputational: Yes/~~No~~
Socio Economic: Yes/~~No~~ - ***Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES***

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

NWSSP Audit and Assurance Services
Internal Audit Thematic Review
Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Sicrhau Gwerth, Arloesi a Rhagoriaeth drwy Bartneriaeth
Delivering Value, Innovation and Excellence through Partnership

Outcomes of C&V UHB Audits completed for the period 2020/21 to 2025/26

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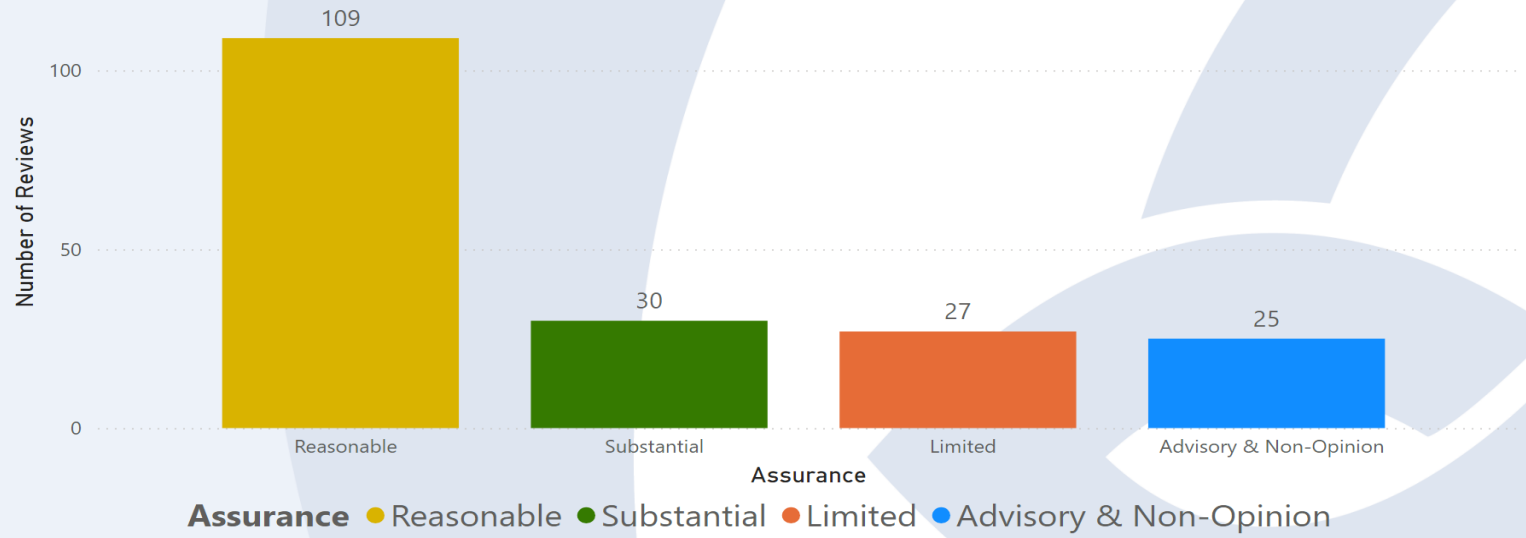
Organisation Comparison

Next Page

, Organisation

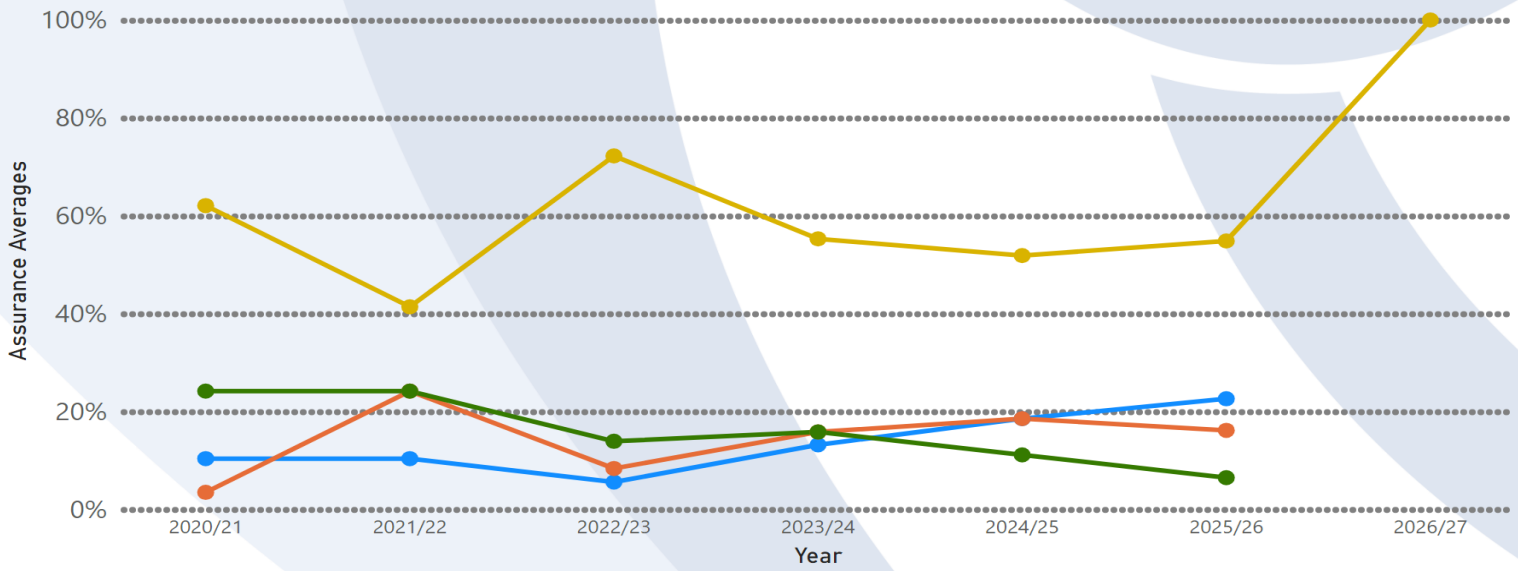
- Select all
- Health Board
  - Aneurin Bevan
  - Betsi Cadwaladr
  - Cardiff & Vale
  - Cwm Taf Morgannwg
  - Hywel Dda
  - Powys THB
  - Swansea Bay
- Trust/SHA
  - DHCW
  - HEIW
  - Joint Commissionin...
  - NHS Wales Perform...
  - NWSSP
  - PHW
  - Velindre
  - WAST

Assurance Ratings Provided



Year	Number of Reviews Completed
2020/21	29
2021/22	29
2022/23	36
2023/24	38
2024/25	27
2025/26	31
2026/27	1
Total	**191**

Assurance Trend



Assurance	2018-23 Present (%)
Advisory & Non-Opinion	13.1%
Limited	14.1%
Reasonable	57.1%
Substantial	15.7%

Assurance Ratings for C&V UHB and All Health Boards for the period 2020/21 to 2025/26

Back to report

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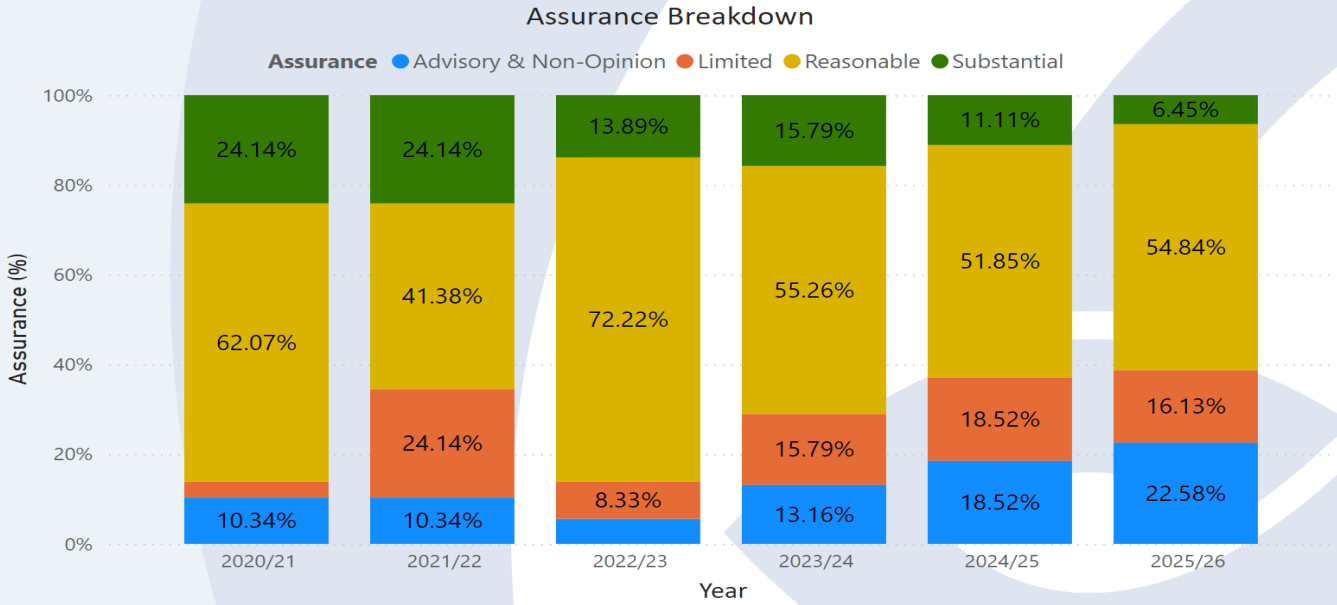
Organisation

- Select all
- Health Board
  - Aneurin Bevan
  - Betsi Cadwaladr
  - Cardiff & Vale
  - Cwm Taf Morgannwg
  - Hywel Dda
  - Powys THB
  - Swansea Bay
- Trust/SHA
  - DHCW
  - HEIW



Show Assurance Trend

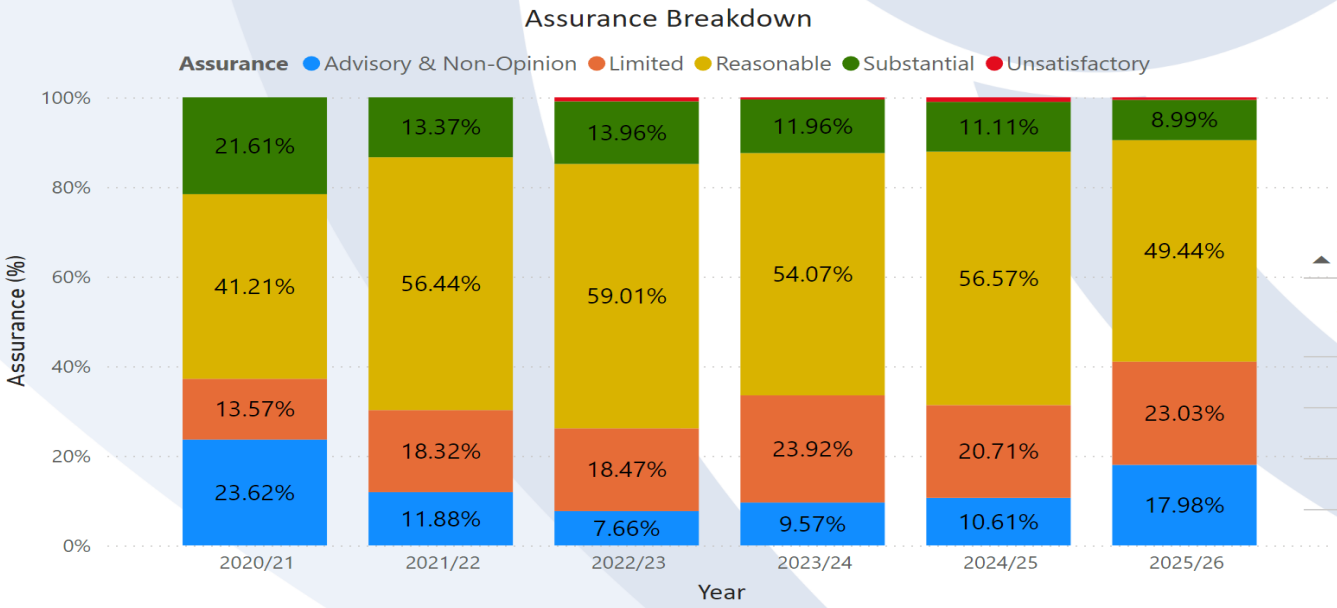
190

Number of Reviews

Assurance	Number of Reviews
Advisory & Non-Opinion	25
Limited	27
Reasonable	108
Substantial	30

Organisation

- Select all
- Health Board
  - Aneurin Bevan
  - Betsi Cadwaladr
  - Cardiff & Vale
  - Cwm Taf Morgannwg
  - Hywel Dda
  - Powys THB
  - Swansea Bay
- Trust/SHA
  - DHCW
  - HEIW



Year

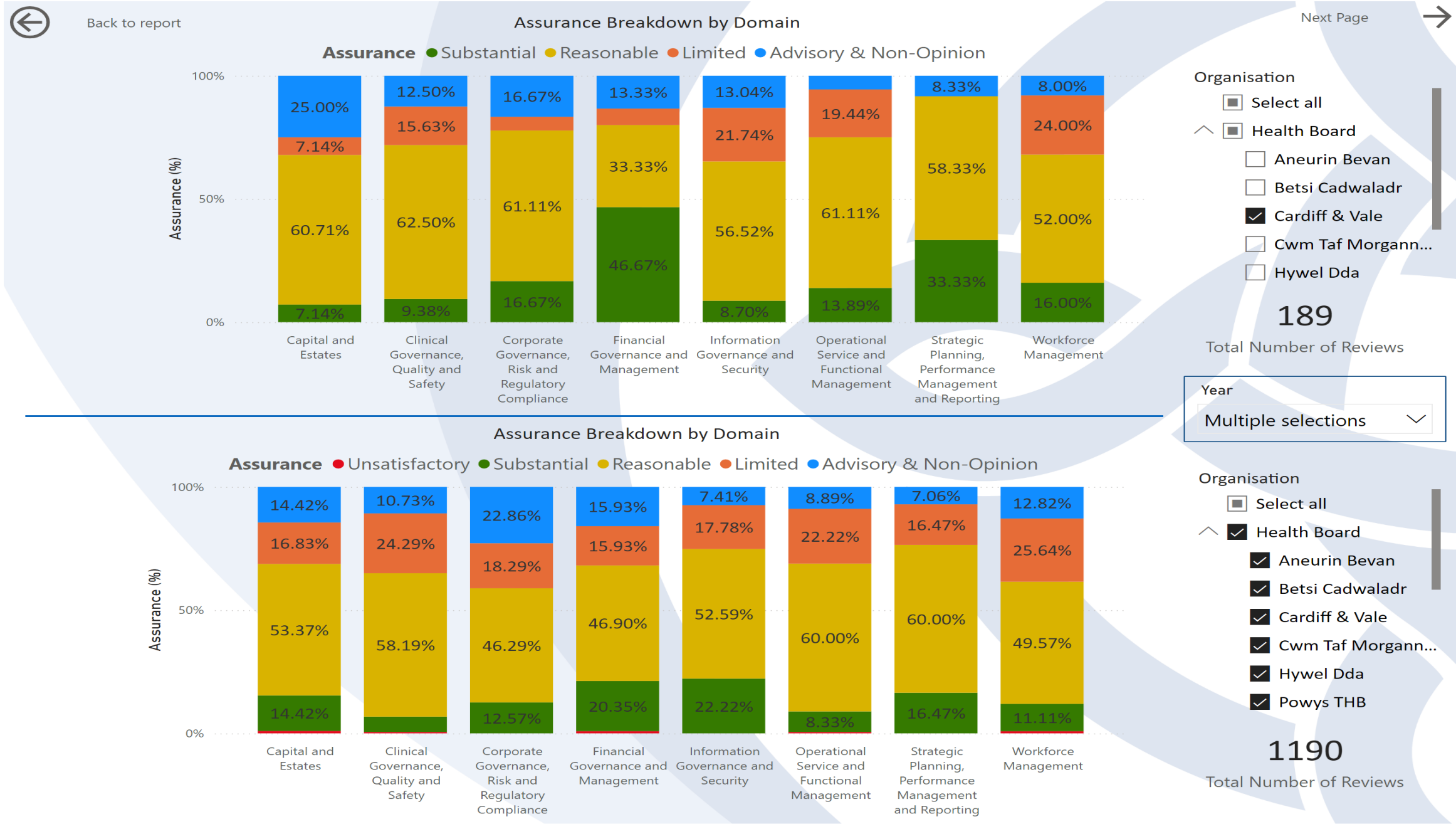
Multiple selections

1208

Number of Reviews

Assurance	Number of Reviews
Advisory & Non-Opinion	161
Limited	237
Reasonable	640
Substantial	164
Unsatisfactory	6

Assurance Ratings by Domain for C&V UHB and all HBs for the period 2020/21 to 2025/26



Analysis of C&V UHB Findings Across The Period 2020/21 to 2025/26

Previous Page

Key Findings Overview | Themes Overview 2022 - Present | Key finding implementation

Next Page

Themes defs

Year: Multiple selections

, Organisation: Health Board ( ) + Cardiff & V...

Domain: All

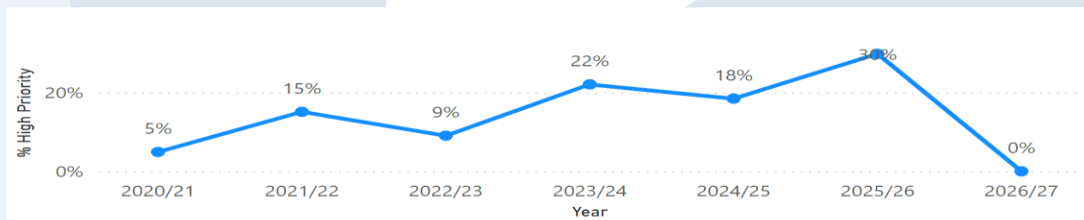
834
Total Key Findings

5.05
Average key findings per review (exc. Advisory)

40%
% Design

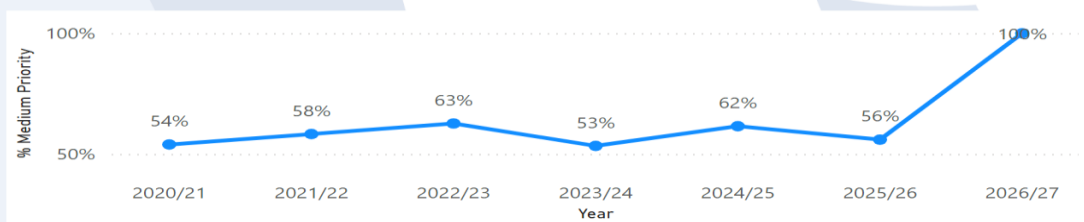
60%
% Operation

17%
High priority key findings



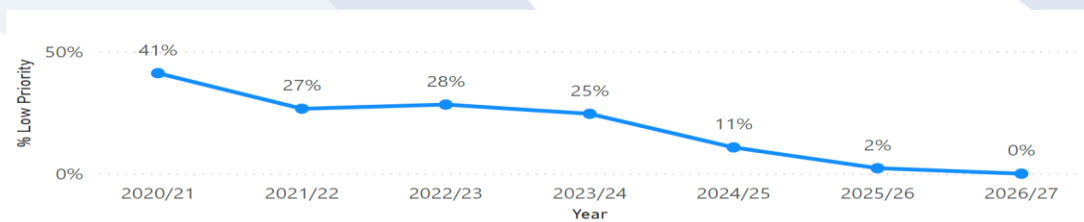
141
High priority key findings

58%
Medium priority key findings



482
Medium priority key findings

22%
Low priority key findings



183
Low priority key findings

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Analysis of The Top 10 Themes for C&V UHB for the Period 2023/24 to 2025/26

Previous Page

Annual Plans | Outcomes Overview | Visual Summaries

Filters:

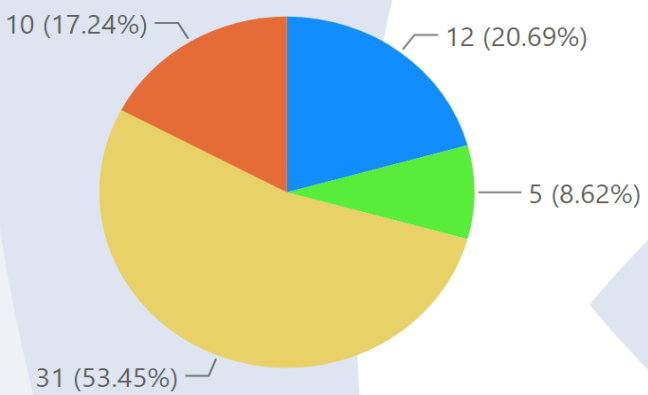
Organisation
Cardiff & Vale

Audit Title
Search

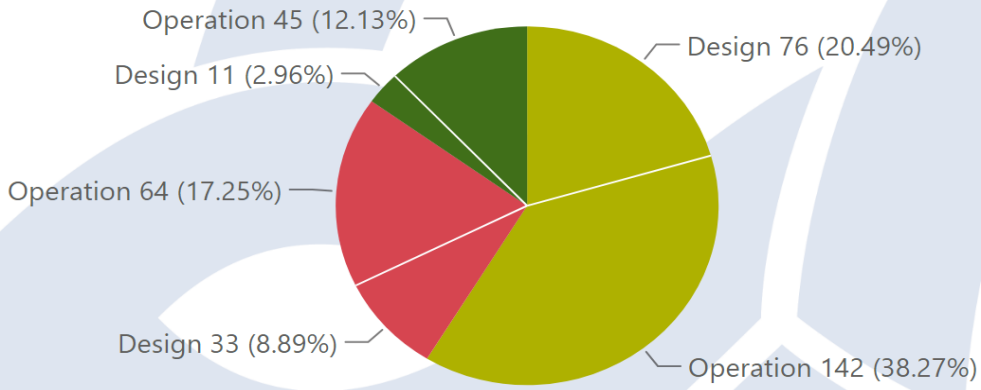
Domain
All

Year
Multiple selections

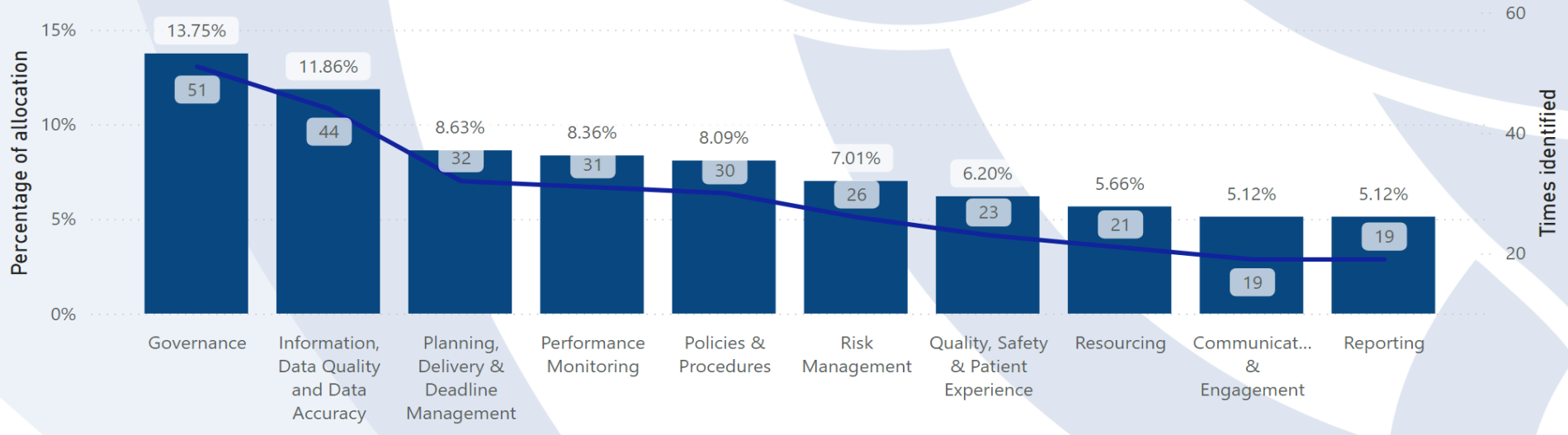
Assurance Advisory & Non-Opinion · Substantial · Reasonable · Limited



Recommendation Priority Medium · High · Low



Top 10 themes



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Analysis of The Top 10 Themes for All Health Boards for the Period 2023/24 to 2025/26

Previous Page

Annual Plans | Outcomes Overview | Visual Summaries

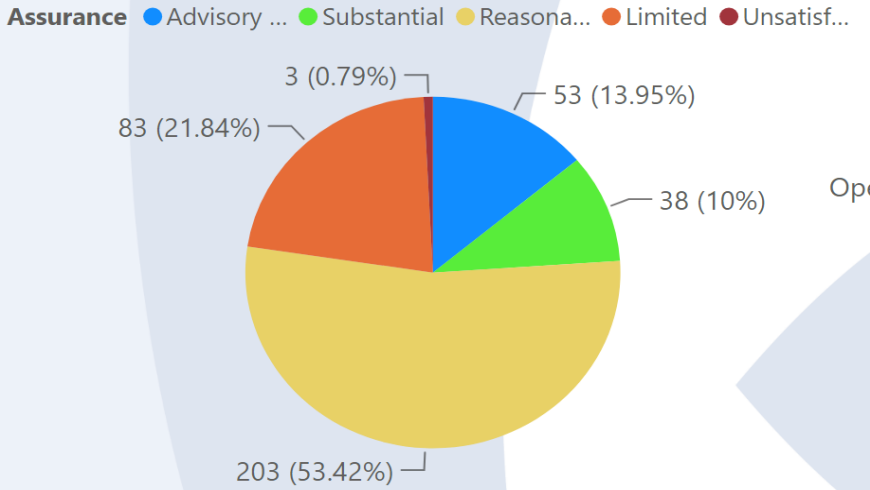
Filters:

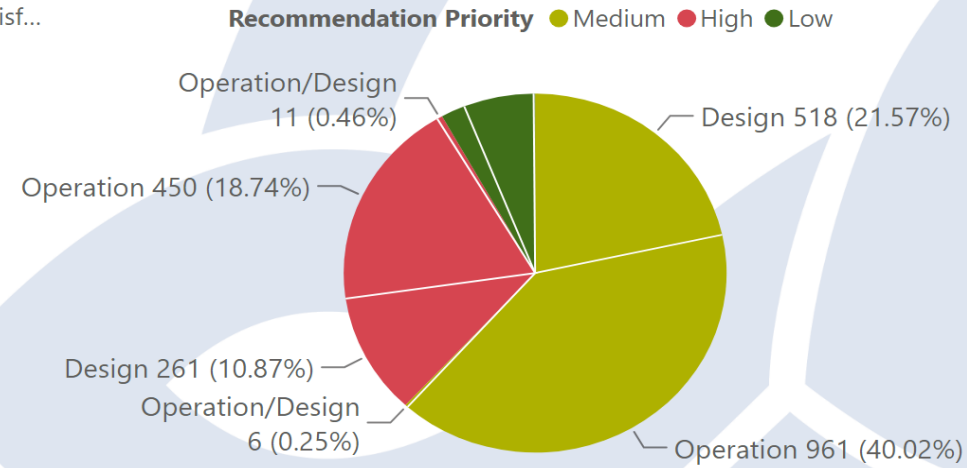
Organisation
Multiple selections

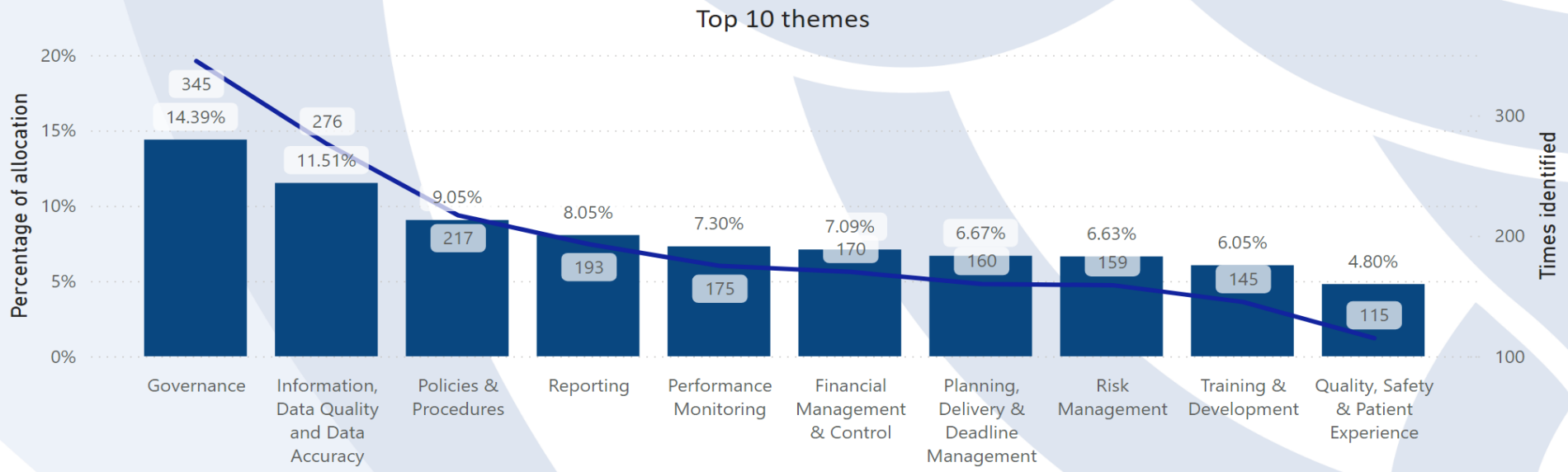
Audit Title
Search

Domain
All

Year
Multiple selections







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Examples of findings within the Governance theme:

Audit Ref	Audit Title	Key Finding Title	Overall Assurance
CVU-2324-16	IMTP Development Process	Strategy Development & Delivery Group Terms of reference	Reasonable
CVU-2324-19	Decarbonisation	Delivery Group and Working Group Terms of reference	Limited
CVU-2324-23	Cancer Services	Executive Cancer Board is not minuted	Reasonable
CVU-2324-24	Mental Health CB Governance	Meeting records	Reasonable
CVU-2324-25	PCIC CB Governance	Frequency of meetings	Reasonable
CVU-2324-27	Follow-up: Medical Records Tracking	Health Records governance requires review	Reasonable
CVU-2324-30	Infection Prevention & Control	IPC Group terms of Reference	Reasonable
CVU-2425-15	Safeguarding	Governance arrangements	Reasonable
CVU-2425-17	Interventions Not Normally Undertaken (INNU)	No effective INNU monitoring mechanism is in place	Limited
CVU-2425-26	Specialist Services CB Governance	Meeting records for decision making groups and governance forums of the SSCB	Reasonable
CVU-2425-29	Consent Process	Public access to out-of-date Consent information.	Reasonable
CVU-2425-29	Consent Process	Consent Group's Term of reference and meeting governance	Reasonable
CVU-2425-30	Records Management	No disposal of records	Reasonable
CVU-2526-01	Risk Management and BAF	Sub-committee review of BAF	Reasonable
CVU-2526-06	Local / Shadow IT systems	Governance	Reasonable
CVU-2526-08	ALN Act	RASG meeting overview and attendance	Reasonable
CVU-2526-08	ALN Act	ALNIG attendance	Reasonable
CVU-2526-09	Medical Equipment and Devices	Lack of Clinical Engineering oversight of Radiology	Reasonable
CVU-2526-11	Staff Overpayments	Oversight and Governance of Staff Overpayments at Clinical Board level	Reasonable
CVU-2526-25	Children and Women CB Governance	Core and Key Governance Meeting Terms of Reference documentation	Reasonable

Examples of findings within the Information Data Quality & Data Accuracy theme:

Audit Ref	Audit Title	Key Finding Title	Overall Assurance
CVU-2223-16	Medical Staff Additional Sessions	Completion of WLI request forms	Reasonable
CVU-2223-16	Medical Staff Additional Sessions	Standardised template for the recording of WLI activity.	Reasonable
CVU-2324-01	Core Financial Systems (Asset Register Management)	Asset register identification labels are not consistently attached to assets.	Substantial
CVU-2324-02	Financial Management within Clinical Boards	Budget holders not accessing financial reports	Reasonable
CVU-2324-09	Health Roster System	Annual leave interface	Limited
CVU-2324-11	Performance Reporting	IPR data is not fully checked for accuracy	Reasonable
CVU-2324-19	Decarbonisation	DAP Funding strategy and quantification	Limited
CVU-2324-23	Cancer Services	Visibility of Single Cancer Pathway Patients	Reasonable
CVU-2324-36	Follow-up: Chemocare IT System	Interface Failure Alerts	Reasonable
CVU-2425-07	Business Continuity Planning	Inconsistent progress with producing plans	Reasonable
CVU-2425-21	Local Data Repository	data governance	Limited
CVU-2425-30	Records Management	Currently there is no formal plan to develop or implement an electronic health record within the health board.	Reasonable
CVU-2425-31	Therapies and Health Sciences Agency and Locum Staff	Incomplete Agency Request Forms	Reasonable
CVU-2425-31	Therapies and Health Sciences Agency and Locum Staff	Insufficient documented evidence to support approval prior to shift being worked.	Reasonable
CVU-2526-13	IMTP / Annual Plan	Unreconciled data within the Minimum Data Set	Reasonable
CVU-2526-17	Nurse Staffing Levels	Incomplete SafeCare completion	Reasonable
CVU-2526-18	Clinical Board Adherence to the Managing Attendance at Work Policy	Missing/Unrecorded self-certifications	Limited
CVU-2526-36	Flexible Working Arrangements for Compressed Hours	Missing / incomplete Flexible Working Request Forms	Limited
CVU-2526-36	Flexible Working Arrangements for Compressed Hours	Recording Flexible Working Hours onto ESR	Limited
CVU-2526-37	Neurodevelopment services for children	Management Information.	Reasonable

Theme definitions

Governance	Inadequate / ineffective governance and oversight structures in place, which may include: · Absence of key roles and associated responsibilities to provide good governance. · Ineffective accountability and reporting structures with the absence of key scrutiny groups/ committees. General weaknesses in the internal control framework that are sufficient to impact the overall governance of the area audited.
Information, Data Quality and Data Accuracy	Systems, processes and procedures that support data accuracy/ quality are poorly designed or are not operating as intended, resulting in poor data quality. There is limited/ no guidance on the expected arrangements for data and information management. Insufficient records are maintained and/ or there are key gaps that would impact decision making. Information and/ or data is of an insufficient quality for monitoring, reporting and decision making.
Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set. Unmonitored scope creep results in missed deadlines, non-delivery of projects and/or tasks, overspends or negative impacts on the quality of the final output.
Performance Monitoring	There are no/ limited systems in place to capture performance information. The systems are ineffective in capturing the required information to manage performance. Performance information is not monitored and/ or shared. Corrective action to address performance issues is not determined or is ineffective.
Policies & Procedures	There are no policies or procedures in place, or they are inadequate to manage the risk. Policies or procedures are overdue for review or do not reflect current operational and/or best practice.
Risk Management	Inadequate/ ineffective risk strategy, appetite and/or management arrangements. The approach to risk management and/ or arrangements applied are not operating as intended.
Quality, Safety & Patient Experience	Findings impacting on the quality and safety of service delivery, or patient experience for example: Concerns management - delays in investigation, high volume of open incidents/complaints etc Non-compliance with quality & safety related statutory/policy requirements (e.g. failing to undertake risk assessments) Issues relating to infection control, waiting list management, patient discharge Issues identified by external reviews (e.g. HIW) have not been addressed

Theme definitions Cont…

Resourcing	Organisational Planning and Management approaches do not incorporate consideration of demand and capacity. Demand and capacity inadequately considered. Lack of proactive review of resources to deliver plans or business-as-usual activities.
Communications & Engagement	There is no clear strategy and / or stakeholder identification arrangements. Information is not communicated clearly internally within teams, or externally with partners or wider stakeholders. Lack of engagement with staff, partners and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
Reporting	Reporting and escalation requirements not clearly defined, including what gets reported where and when. Defined reporting does not provide adequate information to support robust assurance, escalation and risk management. Reporting does not take place at the agreed frequency to the agreed fora in the agreed format, or there is a lack of evidence that reporting is taking place.

Key Observations for Consideration:

* Positive overall annual assurance opinion for each of last 7 years.

* The trend of Limited Assurance reports has been generally rising over the last 4 years to around 20% but is slightly lower than the average for all Health Boards. At the same time, the trend of Substantial assurance has also fallen to around 6% which is again lower than the average for all HBs.

* Limited Assurance reports have been concentrated within the following 4 domains:
  - Clinical Governance, Quality and Safety.
  - Information Governance and Security.
  - Operational Services and Functional Management.
  - Workforce Management.

The Limited Assurance reports include the following:
20/21 – MH CB Outpatient Clinic Cancellations
21/22 – ChemoCare/Clinical Audit/5 Steps/ITIL/NIS/Nurse Bank/Ultrasound Governance
22/23 – Management of HB Policies/Cyber Security/Medical Records Tracking
23/24 – Job Planning/Payroll Costs/Health Roster/Decarb/Alcohol Stds/Estates Condition
24/25 – Health Roster follow-up/INNU/Alcohol follow-up/LDR/Job Planning follow-up
25/26 – Cyber Security/Staff overpayments/CB Sickness Man/Neuro Adult/Flexible Work

* The findings identified through our audits over the last 3 years are split 40% Design and 60% Operation.
This demonstrates that the Health Board generally has effective controls in place, but they are often inconsistently applied in practice.

* The most identified themes are:
  - Governance (13.75%)
  - Information Data Quality and Data Accuracy (11.86%)
  - Planning Delivery and deadline Management (8.63%)
  - Performance Monitoring (8.36%)
  - Policies & Procedures (8.09%)

These are relatively consistent with the most identified themes for all Health Boards, except for the Planning theme which is replaced with Reporting for all Health Boards.

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Partneriaeth Cydwasanaethau
Shared Services Partnership

Diolch yn fawr
Thank you

Delivering Value, Innovation and Excellence through Partnership

Report Title:	Audit Tracker Report			Agenda Item no.		2.3
Meeting:	Audit and Assurance Committee		Public	X	Meeting Date:	01.09.2026
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Director of Corporate Governance					
Report Author:	Corporate Governance Officer					

Background and current situation:

All internal and external (Audit Wales) audits and regulatory bodies that undertake audits and inspections result in actions or recommendations. These are all tracked to ensure they are completed. This report sets out the current status of the audits in detail and provides the committee with oversight of the wider tracking and escalation of actions resulting from regulatory audits and inspections.

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

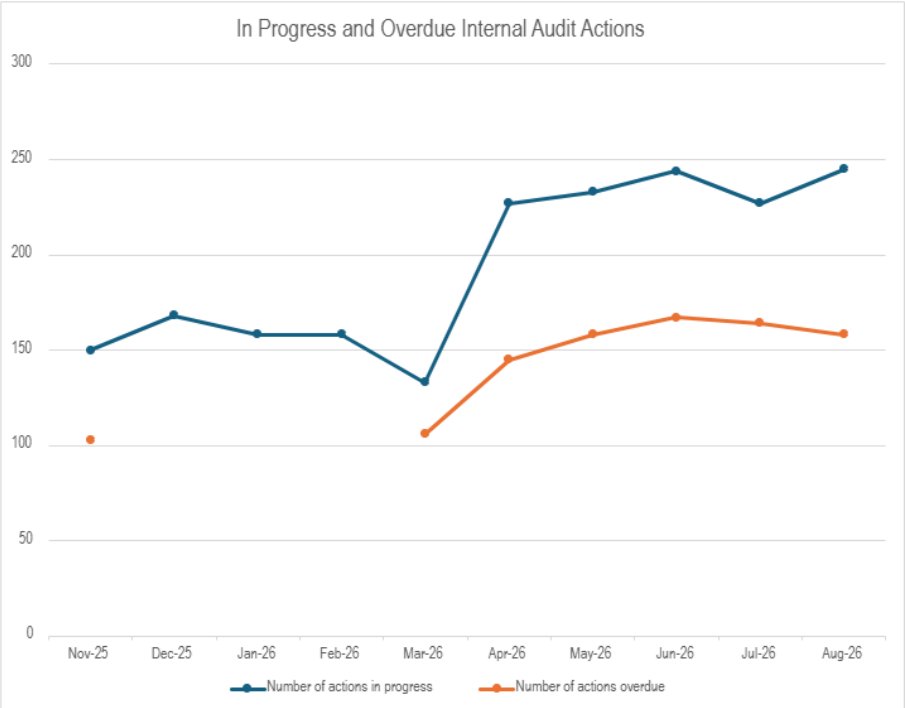
Internal Audit Tracker Update

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

As of the 25th August 2026, there are 245 actions:

- 63 are High Priority (of which 36 are overdue, as set out in Appendix 3)
- 126 are Medium Priority
- 56 are Low Priority (relating to 'Advisory' reports)

Of the 245 actions, 158 (64.49%) are overdue:



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

Appendix 2 sets out the Internal Audit actions with revised deadline dates for the Committee's oversight with an explanation of why an extension has been requested.

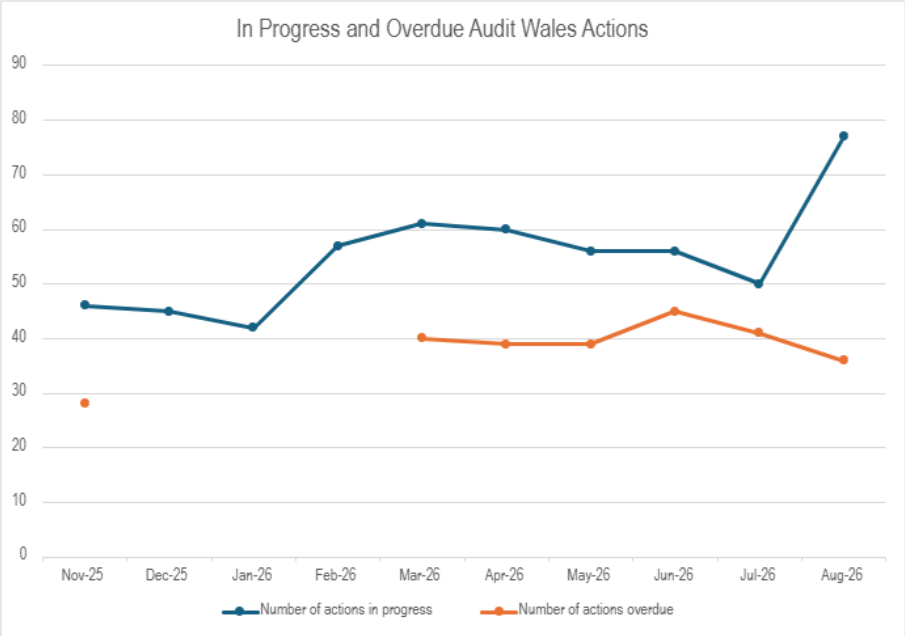
Appendix 3 contains a summary of all ongoing Internal Audit actions as at 25th August 2026.

Audit Wales Tracker Update

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

Since the November 2025 tracker update, 5 additional Audit Wales reports have been issued (two in February 2026, and three in August 2026).

As of 25th August 2026, there are 79 actions which are in progress. Of these 79 actions, 38 (48.10%) of these are overdue:



Appendix 4 provides a list of all closed/completed Audit Wales actions since the previous Audit Committee in November 2025 for the Committee's information.

Appendix 5 sets out the Audit Wales actions with revised deadline dates for the Committee's oversight with an explanation of why an extension has been requested.

Appendix 6 contains a summary of all outstanding Audit Wales actions as at 25th August 2026.

There's too many overdue actions for both.

Corporate Governance will be implementing a revised approach to the performance management of audit actions and will use the Clinical Board Performance Review meetings to hold leads accountable for their actions to ensure that the recommendations as set out within the audit reports are progressed, with a specific focus on improving performance of high priority actions. A further Audit Tracking paper will come

back to the Audit & Assurance Committee in February 2027 to update the Committee on progressing this work.

Regulatory Audit Tracker Update

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

Since the previous update provided in November 2025, Corporate Governance has prioritised reviewing gaps in the regulatory process, particularly around regulatory escalation routes and triggers. **Appendix 7** set out the updated information for the Committee's awareness as work continues.

Appendices:

All of the appendices are located in the supporting documents folder which is located on the MS Teams Channel or the Cardiff and Vale UHB website.

1. Appendix 1 – Internal Audit closed actions since November 2025
2. Appendix 2 – Internal Audit actions with extended deadline dates
3. Appendix 3 – Internal Audit actions in progress as at 25th August 2026
4. Appendix 4 – Audit Wales closed actions since November 2025
5. Appendix 5 – Audit Wales actions with extended deadline dates
6. Appendix 6 – Audit Wales actions in progress as at 25th August 2026
7. Appendix 7 – Regulatory Inspections across the organisation

Recommendation:

The Committee is requested to:

a) Note the information relating to Internal Audit & Audit Wales actions and the revised performance management approach that will be taken to reduce the overdue actions;
b) Note the regulatory audit tracking overview.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

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

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration		Involvement	

tio n									

Quality Impact Assessment Completed?				
Yes		No	X	n/a

Impact Assessment:
Risk: Yes/No
By maintaining an up to date Internal Audit Recommendation Tracker the Health Board mitigates the risk that it may be subject to legal or regulatory penalty.
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

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

Archwilio Cymru
Audit Wales

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

Date issued: August 2026

Contents

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Introduction

This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in 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:** Planning work commenced. Audit to take place in Autumn 2026.
- **Expected committee date:** January 2027 (Board of Trustees)

Performance audit update

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

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work examined digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Complete – final report in today's papers
- **Expected committee date:** September 2026

Progress review: 2019 Clinical Coding Follow-up Review

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

Review of cancer services

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

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

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This work 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:** November 2026

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

Review of the management and prevention of diabetes

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

Operating Theatre efficiency and effectiveness

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

NHS struggling to control day-to-day costs despite continued funding increases / NHS Wales Finances Data Tool 2025–26	July 2026
NHS urgent and emergency care – a system under constant pressure	June 2026
NHS planned care – fit for the future?	June 2026

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

Catherine Mealing-Jones takes up role as Auditor General for Wales	July 2026
The Code of Audit Practice of the Auditor General for Wales	July 2026
Annual Report and Accounts 2025-26	June 2026

There are no relevant Audit Wales consultations currently underway.

Further information

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

Visit our website to find:

Our publications which cover our audit work at public bodies.

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

Data tools to help you better understand public spending trends.

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

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

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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.

Archwilio Cymru
Audit Wales

Clinical Coding Progress Review

Cardiff and Vale University Health Board

April 2026

We have prepared and published this under section 61 of the Public Audit Wales Act 2004.

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Contents

Audit snapshot

What we looked at

1 This review assessed Cardiff and the Vale University Health Board's (the Health Board) progress in implementing recommendations from our 2014 and 2019 reviews of clinical coding. We also examined the actions the Health Board is taking to improve clinical coding performance.

Why this is important

2 Clinical coding converts information about a patient's care into standardised national and international codes, which are used for both inpatient and outpatient care. These codes support hospital funding, service planning, performance monitoring, clinical audit, and assessments of quality and effectiveness. Accurate and timely clinical coding, therefore, is essential for effective patient care and the efficient running of health services.

3 Our 2014 Review of Clinical Coding found that although the Health Board showed a strong commitment to clinical coding, weaknesses in management arrangements, medical records, and engagement with clinical staff were affecting performance. Our 2019 Follow-up Review found improvements in data quality and its use, but concluded that further work was needed to fully address our 2014 recommendations. Of the 25 recommendations made in 2014, 16 remained outstanding in 2019, and we made one new recommendation (see **Appendix 2**).

What we have found

4 The Health Board has made some progress since our last follow-up review, but many long-standing issues remain.

5 Workforce stability within the Clinical Coding Team has improved supported by clearer management arrangements and staff development opportunities. Staff also report a supportive team culture. However, significant senior vacancies remain, and key activities such as validation, audit and training still depend on a small number of individuals. The Clinical Coding Policy and Procedure Manual is outdated and no longer reflects current operational arrangements.

6 Medical records continue to be a major barrier to timely and accurate clinical coding. Although the use of temporary records has reduced and access has improved in some areas, problems persist with record quality, delays in collation, inconsistent tracking and continued reliance on paper records.

7 Board awareness of clinical coding has been maintained and there is a commitment to improvement. However, oversight is limited with reporting focusing narrowly on Welsh Government targets. There is little explanation of the use of coded data and committee oversight is unclear. While the Clinical Coding Team's visibility has improved, clinical engagement remains limited.

8 The Health Board's performance against Welsh Government clinical coding measures and targets has not shown sustained improvement and continues to fluctuate over time. While a range of actions are underway, there is no clear, coordinated plan to drive and sustain long-term improvement.

What we recommend

9 We have made six new recommendations, which replace all outstanding recommendations from our 2014 and 2019 reviews. The recommendations focus on:

- improving shared learning and collaboration between the two clinical coding teams,
- updating the Clinical Coding Policy and Procedure Manual, with a focus on shared responsibility between the coding team and clinical services,
- improving Board visibility and understanding of clinical coding,
- introducing a business partnering model to strengthen clinical engagement, and
- developing a clinical coding plan to address current and future challenges.

Key facts and figures

Of the 17 outstanding recommendations from our 2014 and 2019 reviews, three are complete, three are in progress, and limited progress has been made on 11. We have superseded all outstanding recommendations with new recommendations.

In December 2025, only 66.3% of episodes were coded within one month of a patient being discharged, well below the 95% target. Cardiff and Vale University Health Board was the lowest performing health board in this measure across Wales at the time.

In February 2026, only 21.8% of coding errors were corrected by the next monthly reporting deadline, well below the 90% target.

General medicine, midwifery and paediatric services recorded the most uncoded episodes.

The Clinical Coding Team currently has eight senior vacancies - a Clinical Coding Manager, a Training and Compliance Manager, and six Senior Clinical Coders.

Our findings

Implementation of previous recommendations

Despite taking some positive steps to improve the service, a number of issues remain unresolved, which continue to affect performance and assurance

Clinical coding resources

10 Our previous reviews highlighted weaknesses in the management, stability and supervisory capacity of the clinical coding team. Since then, the Health Board has finalised its clinical coding team structure, and management arrangements are clearer. In September 2023, the team also moved from the Digital and Health Intelligence Directorate to the Clinical Diagnostics and Therapeutics Clinical Board. This change was intended to raise the profile of clinical coding and provide clearer governance, structure, and oversight.

11 The creation of an Assistant Clinical Coding Manager in 2025 has reduced some operational pressures previously absorbed by the Head of Clinical Coding. However, many other senior posts intended to provide oversight and supervision remain vacant (see **Exhibit 1**). These include the Clinical Coding Manager role, the Trainer and Compliance Manager role, and six of the seven Senior Clinical Coder roles. As a result, management capacity within the team remains limited, which constrains its ability to focus on strategic planning, service improvement, and collaborative working. This situation reduces service resilience and increases the risk of further deterioration in performance.

Exhibit 1: roles and vacancies in the clinical coding team

	Number of posts in structure	Number of vacancies
Head of Clinical Coding	1	0
Clinical Coding Manager	1	1
Assistant Clinical Coding Manger	1	0
Trainer and Compliance Manager	1	1
Senior Clinical Coder	7	6
Clinical Coder	7	0
Coding Trainee	11	0
Support Officer	4	0
Total	**33**[1]	**8**

Source: Data provided by Cardiff and Vale University Health Board

12 Effective clinical coding relies on robust validation and quality assurance arrangements. While routine checks are carried out, particularly for work completed by trainee coders, these arrangements are largely informal, relying on a small number of experienced staff with limited capacity. The Health Board was planning to recruit an accredited Clinical Coding Auditor and a Trainer and Compliance Manager. However, due to recruitment challenges, these posts remain vacant. The Health Board plans to assess the feasibility of recruiting to these roles as part of the team's workforce review. This means that validation processes are not yet stable or consistent, limiting assurance over data quality.

[1] The total clinical coding Full Time Equivalent (FTE) is 32.46

13 Recruiting and retaining clinical coding staff remains challenging. The Health Board has lost a number of staff to English NHS Trusts as they offer higher pay, operate digital medical records, and provide greater homeworking opportunities for coders. The Health Board has taken steps to address this, including investing in agency staff to support with backlog work. As a result, workforce stability has improved and staff now report a supportive team culture, improved flexible working, and a clearer management structure. Staff were also positive about the team's move into the Clinical Diagnostics and Therapeutics Clinical Board. However, if senior vacancies remain unfilled, the team will continue to lack the capacity needed to cope with pressures and make lasting improvements. This risks undermining the sustainability of recent progress.

Staff training and development

14 Our 2019 follow-up review found several weaknesses in staff training and development. These included coders not being rotated across specialties, a lack of clarity about training and induction, and coding teams not having regular meetings to share learning.

15 Since then, the Health Board has made some improvements. It has adopted a 'grow your own' approach to developing coding staff and has introduced a new internal clinical coding qualification, which four coders have completed so far. Several other team members are also interested in completing the qualification to support their career progression. The team has also developed a mentoring culture, with support available beyond trainee coders. The Health Board has also reviewed how specialties are allocated across the team. This has helped broaden experience and improve cover when staff are absent. Coders who took part in our focus group described a supportive and collaborative team, with good opportunities for progression.

16 However, these opportunities are constrained by limited team capacity. Training, mentoring and support rely heavily on a small number of experienced coders, and arrangements remain largely informal. This reliance on a small number of experienced coders limits the consistency and scalability of training and development arrangements. There is an opportunity, therefore, to clarify and formalise expectations for training and development, including mentoring arrangements and rotation between specialties, by updating the Clinical Coding Policy and Procedure Manual (see **paragraph 20**).

17 The Health Board's plan to recruit a Clinical Coding Trainer and Compliance Manager is under review. Staff consider this role to be critical to strengthening training arrangements and improving the team's overall performance.

18 Clinical coding is carried out by two separate teams, one at University Hospital of Wales (UHW) and the other at University Hospital Llandough (UHL), both managed by the Head of Clinical Coding. Although the teams work independently, there is some collaboration. However, they do not hold joint team meetings, and there is scope to create more formal opportunities to share learning and standardise practice.

Policy and procedure

19 Our 2019 review found that the Health Board had not update its Clinical Coding Policy.

20 Since then, the Health Board has issued a new Clinical Coding Policy and Procedure Manual in November 2021. However, the Clinical Coding Policy and Procedure Manual has not been reviewed and updated since November 2022. The policy and manual, therefore, are out of date and no longer reflect current management arrangements or the revised structure of the Clinical Coding Team. As a result, it does not provide a clear or reliable reference for staff or the services the team works with.

21 Updating the policy and procedure provides an opportunity to clarify how clinical coding works. The revised policy and procedure should clearly set out the roles, responsibilities and expectations of the clinical coding team and clinical services. This would support more consistent practice, clearer accountability and more effective working arrangements across the Health Board. Once updated and approved, the policy and procedure should be clearly communicated to all clinical services.

Medical records

22 Our 2019 follow-up review found that ongoing problems with medical records continued to affect the timeliness and accuracy of clinical coding. These issues included the use of temporary records, difficulties tracking case notes, poor record quality, and delays in accessing records, including the Teenage Cancer Unit.

23 Since then, the Health Board has made some improvements. The use of temporary medical records has reduced, and access to Teenage Cancer Unit records has improved. The relocation of the Clinical Coding team to UHW has also improved access to paper records.

24 However, the quality and availability of medical records continue to present a significant barrier to timely and accurate clinical coding. Records remain largely paper-based, and coders continue to experience delays due to missing documentation, poor handwriting, mixed-up patient notes, and storage pressures. Delays in collating medical records[2], linked to the limited capacity of the collating team, contribute to backlogs and slow the coding process. In some cases, wards request records back before coding is complete, further delaying completion.

[2] Collating medical records is the process of bringing together all documents for a patient's episode of care into one complete, organised record, so they can be used for care, record management, and clinical coding.

25 The quality of medical records remains inconsistent, and the Health Board does not have a clear system in place to routinely monitor the quality of records. It has not adopted the Royal College of Physicians' standards for medical record keeping nor has it trained clinical staff on the importance of good quality records and its wider impacts.

26 The Clinical Coding Team uses the Patient Administration System (PAS) to track medical records, but use of the system is inconsistent across services. In some cases, records are not added to PAS until they reach the Clinical Coding Team, limiting visibility and delaying coding. These issues are partly due to limited training and the use of multiple digital systems alongside PAS.

27 The completion of discharge summaries also remains inconsistent and continues to constrain timely and accurate clinical coding. Some discharge summaries are incomplete when sent for coding, while others are not completed at all. Operational pressures on clinical staff and the use of multiple digital systems, including electronic discharge summaries, may be contributing factors.

28 Greater digitisation would improve patient care and support clinical coding by making medical records clearer, more complete and easier to access. Indeed, the Health Board's long-term strategy[3] commits the organisation to become fully paperless by 2035. However, while some services, including maternity and ophthalmology, have begun to digitise their records, progress has been slow, and most medical records remain paper-based. We are currently carrying out a separate review of digital transformation at the Health Board and will comment separately on Electronic Records Management as part of that work.

Board engagement

29 Our 2019 follow-up review found that the Board had a good awareness of clinical coding and received regular performance information. However, further work was needed to improve understanding of how clinically coded data is used.

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[3] Shaping Our Future Wellbeing Strategy

30 The information the Board receives on clinical coding is generally limited to the two Welsh Government targets reported through the Integrated Performance Report (see **paragraph 28 and 30**). However, the report provides little explanation of why performance is improving or deteriorating, how coded data is used, or whether current actions are having an impact on service improvement. This limits the Board's ability to understand the causes of underperformance or assess whether current actions are delivering improvement.

31 Board level oversight for clinical coding is unclear. It is not clear which committee is responsible for monitoring performance, providing challenge, and driving improvement. While clinical coding is sometimes discussed by the Digital and Infrastructure Committee, this is not consistent, and there is no routine report focused specifically on clinical coding.

32 Although the 2025-26 Annual Plan identifies improving clinical coding as a key priority within the Health Board's Shaping Our Future Infrastructure portfolio, there is currently no overarching improvement plan for clinical coding (see **paragraph 33**). This makes it difficult for the Board to track progress or gain assurance that key issues, such as workforce capacity, quality of medical records, and clinical engagement, are being addressed appropriately and effectively.

Clinical engagement

33 Our 2019 review found that more needed to be done to involve clinical staff in the clinical coding process. We highlighted the need for ongoing training to improve their understanding of clinical coding and their role in supporting good quality data.

34 There is little evidence that clinical staff receive regular training on the importance of clinical coding or how their records affect coding quality and performance. Clinical staff are also not routinely involved in coding validation or review activities, limiting opportunities to improve data quality and shared learning.

35 There is no clear or coordinated approach to support wider clinical engagement across the Health Board. While the relocation of the Clinical Coding Team to UHW has improved visibility, routine engagement with clinical services remains limited. While some early collaborative work is underway with individual specialties, such as stroke services, this activity is ad hoc and constrained by capacity. To make sure there is structured and sustainable engagement with clinical services, the coding team should implement a business partnering model or similar.

Performance and improvement

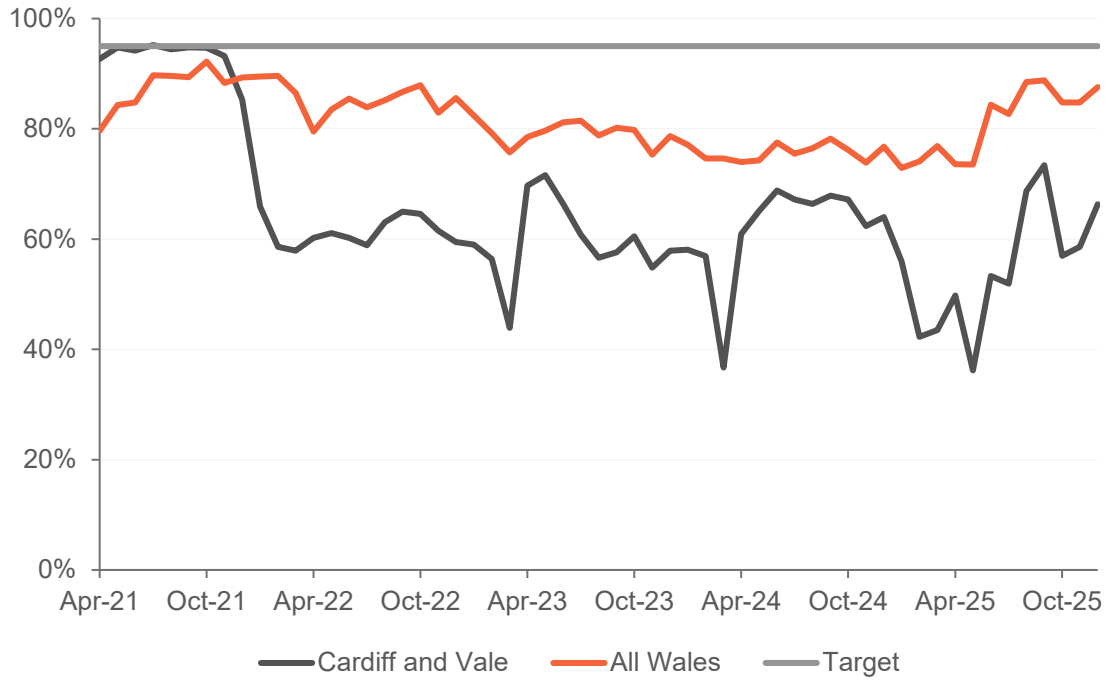
The Health Board has consistently missed Welsh Government targets for clinical coding completeness and accuracy and urgently needs a coordinated plan for improvement

Clinical coding performance

36 Despite the progress the Health Board has made in addressing some our previous recommendations, the improvements do not seem to have had a noticeable impact upon its clinical coding performance.

37 The Welsh Government has set two performance measures and targets for clinical coding. The first measure is that all health bodies must complete clinical coding for each patient episode within one month of the patient's discharge, with a target of 95%. **Exhibit 2** shows that the Health Board is not meeting this target. Performance fell after November 2021 and has since remained variable and consistently below both the target and the Wales average.

Exhibit 2: percentage of all episodes coded within one month of the episode end date

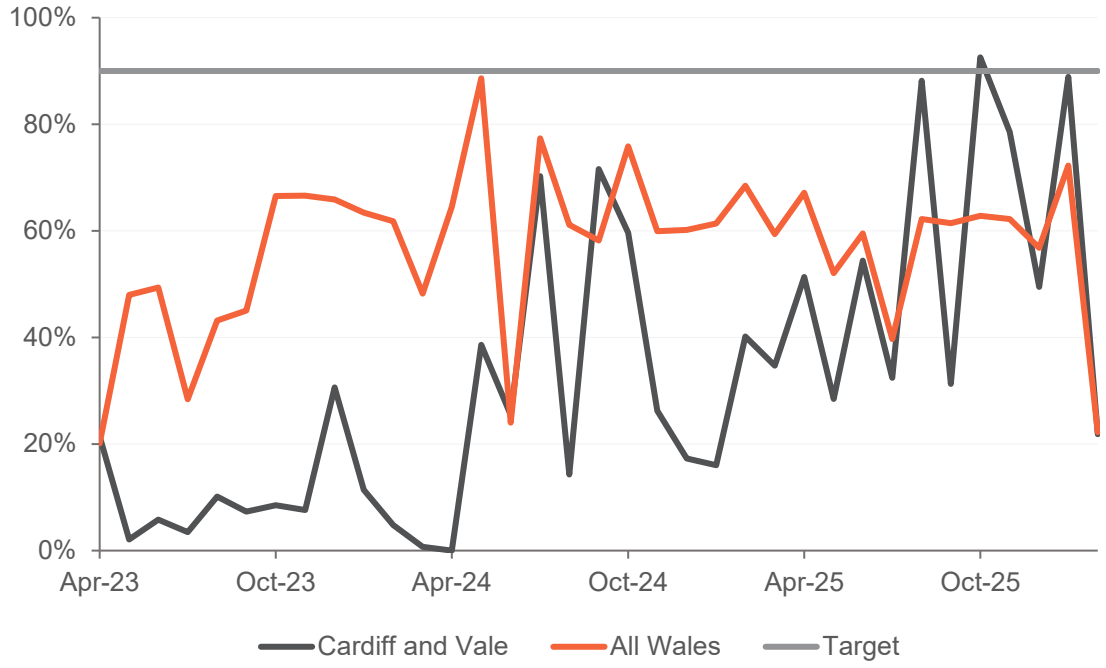


Source: Audit Wales analysis of Digital Health and Care Wales data

38 In 2024-25, there were 30,223 uncoded episodes, which was 19% of all episodes. By November 2025, this had increased to 34,738 uncoded episodes, representing 34% of the total. This is a significant rise (15%) from the previous year. Most of the uncoded episodes were in general medicine, midwifery, and paediatric services.

39 The second measure is that all health bodies must correct any coding errors by the time they submit their next monthly report, with a target of 90%. **Exhibit 3** shows that the Health Board's performance against this measure is inconsistent and remains well below target. Although there are occasional improvements, they are not sustained and usually followed by a sharp decline. Between April 2023 and February 2026, the Health Board met the target only once and its performance is generally below the Wales average.

Exhibit 3: percentage of clinical coding errors corrected within 35 days



Source: Audit Wales analysis of Digital Health and Care Wales data

40 The reasons for underperformance are well understood by the Health Board, and include many of the challenges noted earlier, such as recruitment and retention, management capacity, the quality of medical records, and clinical engagement. However, as noted previously, the Health Board should do more to explain this underperformance to Board.

Actions to improve performance

41 The Health Board has shown a clear commitment to improving clinical coding performance and has already taken some positive steps as noted earlier. The 2025-26 Annual Plan also commits the Health Board to developing a Sustainable Clinical Coding Plan. Planned actions include:

- developing a plan for paperless medical records,
- moving to digital only coding for cataract surgery,

- exploring a move to digital coding options, and
- developing a sustainable workforce and training plan.

42 However, we found no evidence that these actions have been brought together yet into the single, fully developed Sustainable Clinical Coding Plan set out in the Annual Plan. While the team has improvement plans for individual projects, the absence of an overarching plan makes it difficult to understand the short- and long-term improvement aims for the service, the associated financial and workforce requirements, and how progress will be monitored.

43 Furthermore, most of the planned improvements depend on investment in digital systems. The Health Board's five-year Digital Strategy, which includes clinical coding, is now outdated. Although the strategy is due to be updated, the Clinical Coding Team has not yet been involved. It is important that the digital and clinical coding teams work together to ensure the updated Digital Strategy and Clinical Coding Sustainability Plan align and support each other.

Recommendations

We have made six new recommendations, which replace all outstanding recommendations from our 2014 and 2019 reviews (see **Appendix 2**).

R1 To help shared learning, the two coding teams, based at UHW and UHL, should hold regular team meetings. (**paragraph 18**)

R2 The Health Board should update its Clinical Coding Policy and Procedure, emphasising shared responsibility for clinical coding. For example, by setting out:

- clinical coding team responsibilities,
- clinical services responsibilities,
- expectations for:
  - the quality of clinical documentation,
  - the availability and tracking of medical records,
  - use of systems such as the Patient Administration System,
  - training and development of coding and clinical staff, and
  - engagement arrangements between the coding team and services. (**paragraph 20**)

R3 To help the Board better understand clinical coding performance, the Health Board should clearly explain, in the Integrated Performance Report, the main factors affecting clinical coding performance. (**paragraph 21**)

R4 To show how clinical coding data is used, the Health Board should clearly identify in Board and committee papers when coded data has been used to support planning, performance monitoring, or decision-making. (**paragraph 21**)

R5 To strengthen clinical engagement, the coding team should introduce a business partnering approach, or a similar model. (**paragraph 26**)

R6 The Health Board should develop its Sustainable Clinical Coding Plan to address current and future challenges. The Health Board should ensure the plan:

- is costed, at a minimum, for the medium term (3-5 year),
- is supported by a workforce plan, including a plan to reduce use of agency staff,
- developed with clinical services,
- aligns with the digital strategy,
- includes clear milestones and performance trajectories, and
- ensure an appropriate committee receives regular progress updates.

The Health Board should also ensure that the Sustainable Clinical Coding Plan addresses the actions detailed in Recommendations 1-5 above. **(paragraph 33)**

Appendices

1 About our work

Scope of the audit

We have assessed whether the Health Board has implemented the Auditor General's recommendations in full to improve clinical coding arrangements and performance.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Has the Health Board implemented all outstanding recommendations from the 2014 Review of Clinical Coding and the new recommendation made in the 2019 Clinical Coding Follow-up Review?
- Does the Health Board have a clear plan and accountability arrangements in place to improve clinical coding performance?
- Is the Health Board's performance against Welsh Government targets for timely and accurately coded data improving?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it had:

- made the expected progress in implementing our 2014 and 2019 audit recommendations (set out in **Appendix 2**) to address the issues and concerns identified in the audits.
- plans in place to improve clinical coding performance.

Methods

We undertook our audit work between November 2025 and February 2026.

We reviewed the following key documents:

- Annual Plan 2025-2026,
- 5 Year Digital Strategy,
- Integrated Performance Reports,
- DHCW clinical coding performance dashboards,
- Public Board papers,
- Quality Committee papers,
- Strategic Leadership Team meeting papers,
- Public Digital and Infrastructure Committee papers,
- Digital Health and Intelligence Committee papers,
- Clinical coding project and workforce plans,
- Policies and procedures, and
- Training resources.

We interviewed the following:

- Chief Operating Officer
- Directorate Manager for the Clinical Diagnostics and Therapeutics Clinical Board
- Director of Operations for Clinical Diagnostics and Therapeutics
- Head of Clinical Coding
- Assistant Clinical Coding Manager
- Clinical Lead for Stroke and Neurologist

We also facilitated a focus group with a selection of clinical coding staff.

2 Previous recommendations

The table below shows the Health Board's progress against recommendations from our 2014 and 2019 reviews. All outstanding recommendations from those reviews have been replaced by new recommendations on **page 19**.

Clinical Coding Resources (2019)

R1 Resolve the current interim arrangements by agreeing the coding management structure following the directorate reconfiguration, ensuring there is sufficient management and supervisory capacity (**complete, see paragraph 10**).

Clinical Coding Resources (2014)

R1 Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include:

c) ensuring that there is capacity to allow Band 4 Coders to undertake mentoring and checking of coding of Band 3 staff in line with job descriptions (**in progress, see paragraph 15**),

d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years (**in progress, see paragraph 15**),

g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge (**limited progress, see paragraph 18**),

h) updating the clinical coding policy to reflect the current operational management arrangements (**limited progress, see paragraph 19**), and

k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited Clinical Coding Auditor (**limited progress, see paragraph 12**).

Medical Records (2014)

R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include:

a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards (**limited progress, see paragraph 25**),

b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS) (**limited progress, see paragraph 26**),

c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW (**limited progress, see paragraph 24**),

e) reducing the level of temporary medical records in circulation (**complete, see paragraph 23**),

f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders (**complete, see paragraph 23**), and

g) revisiting the availability of training on the importance of good quality medical records to all staff (**limited progress, see paragraph 25**).

Board Engagement (2014)

R3 Build on the good level of awareness of clinical coding at Board to ensure members are fully informed of the Health Board's clinical coding performance. This should include:

c) raising the awareness amongst Board members of the wider business uses of clinically coded data (**limited progress, see paragraph 21**).

Clinical Engagement (2014)

R4 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:

a) reinforcing the importance of completing discharge summaries to aid the coding process (**limited progress, see paragraph 27**),

b) ensuring that clinical staff receive an appropriate level of on-going training with regards to the process and purposes of clinical coding, outside of initial junior inductions (**limited progress, see paragraph 25**),

c) establishing validation processes that involve clinical staff, which will act to both improve clinical engagement and act as a form of accuracy review (**limited progress, see paragraph 25**), and

d) improving the 'visibility' of coding staff, to ensure that clinical engagement operates as a two-way process (**in progress, see paragraph 26**).

3 Key terms in this report

Term	Description
Discharge summary	A clinical document completed when a patient leaves hospital, which summaries the patient's care during that hospital stay.
Electronic Patient Record (EPR)	Is a computer-based record of a patient's health and care, which replaces or supplements paper medical notes.
Integrated Performance Report	A regular Board-level report that brings together information on quality, performance, finance and workforce to provide a single, joined-up view of how the organisation is performing.
Patient Administration System (PAS)	A core administrative IT system used to record, track and manage patient activity.
Patient episode	A patient episode (or episode of care) is a defined period of treatment or service provided to a patient, starting from a referral and ending at discharge.
Royal College of Physician (RCP) standards	National professional standards that define how patient records should be structured, completed and maintained to ensure safe, high-quality care.
Validation	The process of verifying that data recorded is correct and reflects the patient's care pathway.

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

Management response form

Audited body	Cardiff and Vale University Health Board
Audit name	Clinical Coding Progress Review (Follow-up)
Date response received	11/05/2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	To help shared learning, the two coding teams, based at UHW and UHL, should hold regular team meetings	The Head of Clinical Coding, alongside existing site-based team meetings, will introduce joint team meetings. The frequency will be bi-monthly, with meetings held predominantly via MS Teams. Where practical, bi-annual face to face meetings will take place.	May 2026	Head of Clinical Coding
R2	The Health Board should update its Clinical Coding Policy and Procedure, emphasising shared responsibility for clinical coding. For example, by setting out:	The Health Board will revise its Clinical Coding Policy and Procedure to include all the elements specified in the report. Consultation with the National Standards team will be undertaken, and the updated policy will be presented through established Health Board governance channels for approval.	July 2026	Directorate Manager, Clinical Coding, Outpatient Nursing & Patient Administration

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	• clinical coding team responsibilities, • clinical services responsibilities, • expectations for: − the quality of clinical documentation, − the availability and tracking of medical records, − use of systems such as the Patient Administration System, − training and development of coding and clinical staff, and − engagement arrangements between the coding team and services.			
R3	To help the Board better understand clinical coding performance, the Health Board should clearly explain, in the Integrated Performance	The Integrated Performance Report will include details of clinical coding performance, including the main factors affecting clinical coding performance.	June 2026	Director of Operations, Clinical Diagnostics and Therapies

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	Report, the main factors affecting clinical coding performance.			
R4	To show how clinical coding data is used, the Health Board should clearly identify in Board and committee papers when coded data has been used to support planning, performance monitoring, or decision-making.	The Health Board will strengthen the visibility of clinical coding data within Board and committee reporting arrangements. As part of the development of the 2026/27 performance and assurance framework, report templates and author guidance will be reviewed to require explicit reference to where clinical coding data has informed planning, performance monitoring, service improvement, or decision-making. This will initially be implemented through key corporate and operational reporting routes, with oversight from the Executive Team, and will support a more consistent approach across departments. Arrangements will be reviewed during 2026/27 to ensure the use of clinical coding intelligence is	January 2027	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		routinely evidenced and clearly communicated at Board and committee level.		
R5	To strengthen clinical engagement, the coding team should introduce a business partnering approach, or a similar model.	The clinical coding service is currently facing significant workforce challenges. There is an ongoing reliance on external coders, paired with a shortage of senior clinical coders within the department. Due to these constraints, the service must maintain a centralised operational model. Leadership and engagement with clinical boards and clinicians therefore falls to the senior managers and the coding manager, who continue to guide and support collaborative efforts with clinical teams. The department will keep the current approach under ongoing review. As the workforce situation improves in the future, there are plans to transition to a business partner model. This would involve assigning senior clinical coders to individual clinical boards, thereby strengthening direct clinical	January 2027	Head of Clinical Coding

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		engagement and support. Based on current recruitment, training and development plans, CAV is unlikely to have enough senior coders to fully implement a business partnering model for around 18 months. This position will be kept under regular review.		
R6	The Health Board should develop its Sustainable Clinical Coding Plan to address current and future challenges. The Health Board should ensure the plan: • is costed, at a minimum, for the medium term (3-5 year), • is supported by a workforce plan, including a plan to reduce use of agency staff, • developed with clinical services, • aligns with the digital strategy, • includes clear milestones and performance trajectories, and	**Development of the SCCP** The Health Board is committed to developing a comprehensive and adaptive Sustainable Clinical Coding Plan (SCCP). This plan will address all required aspects. A Strategic Workforce Plan for Clinical Coding covering a 3-5 year period will be further developed. This workforce plan will incorporate indicative costing models to ensure future sustainability and strategic planning. **Alignment with Recommendations** The SCCP will be designed to include and align with the plans and commitments associated with Recommendations 1 to 5. This integration will ensure a cohesive approach, linking the SCCP to	September 2026	Director of Operations, Clinical Diagnostics and Therapies

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	• ensure an appropriate committee receives regular progress updates. The Health Board should also ensure that the Sustainable Clinical Coding Plan addresses the actions detailed in Recommendations 1-5 above.	existing and forthcoming initiatives within the Health Board.		

Archwilio Cymru
Audit Wales

Are cancer services improving?

Cardiff and Vale University Health Board

August 2026

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot

What we looked at

1 We looked at Cardiff and Vale University Health Board's (the Health Board's) approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and oversees service performance.

2 We also reviewed trends in cancer service performance. Our 2025 national report on cancer services highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality.

Why this is important.

3 Demand for cancer services is increasing, driven by factors such as:

- an ageing population;
- rising levels of obesity and alcohol use;
- better survival rates, meaning patients need ongoing monitoring; and
- the introduction of new tests and treatments.

4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life. This increases pressure on health boards to deliver timely care.

5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and new tests and treatments.

What we have found

6 The Health Board is not making enough progress to ensure timely and equitable access to cancer diagnosis and treatment. Performance against the Suspected Cancer Pathway (SCP) remains below the 75% target. In 2025–26, only 63.2% of patients started treatment within 62 days. The Health Board has however, managed a substantial increase in cancer service demand without a corresponding significant worsening of waiting times performance. Although short-term recovery actions have helped the Health Board manage demand growth, they are not delivering lasting improvement.

7 The Health Board's approach to planning cancer services lacks focus. It has set priorities in its Cancer Strategy, but has not produced a single, costed delivery plan. Instead, it relies on annual plans, limiting long-term impact. Planning is reactive, focusing on immediate pressures rather than future capacity and demand. Cancer costs continue to rise faster than inflation, without a long-term financial plan.

8 The Health Board uses data to monitor current performance but makes limited use of forecasting, capacity planning, and experience and outcomes data. Consequently, it is unable to demonstrate that its actions will improve services or meet expected levels of performance.

9 The Health Board identifies cancer risks and targets preventative action at higher-risk groups. However, it lacks good quality screening uptake data, limiting its ability to target inequalities. Financial pressures also reduce the scale and long-term impact of prevention work.

10 The Health Board has clear leadership arrangements overseeing current performance. However, it has not appointed a clinical leader for cancer services or maintained a Cancer Board. This weakens clinical input and makes it harder to co-ordinate long-term improvement.

What we recommend

11 We have made six recommendations in the following areas:

- developing a costed improvement plan to deliver the strategy, with supporting resource plans and delivery actions and milestones;
- working with partners to improve availability of cancer screening data;
- make better use of data to support prevention, intervention, and screening uptake;
- appointing a clinical lead for cancer services;
- strengthening governance and improving accountability by re-establishing the Cancer Delivery Board; and
- collecting and using patient experience and outcomes data to inform planning.

Key facts and figures

The number of new suspected cancer referrals rose by 25% between 2022–23 and 2025–26.

Spending on cancer services rose from £73 million to £111 million between 2019–20 and 2023–24. This is £18 million more than if spending had kept pace with inflation over the same period.

In March 2026, most referrals were for suspected breast (453), skin (404), lower gastrointestinal (387), and upper gastrointestinal (363) cancers.

In March 2026, 63.2% of patients started treatment within 62 days, compared with the 75% target.

In March 2026, there was wide variation in treatment waiting times. Performance ranged from 95% for skin cancer to just 41% for lower gastrointestinal cancer, against a 75% target.

Between 2002 and 2024, one-year cancer mortality rates have fallen by 20%.

Our findings

Cancer service improvement planning

The Health Board manages short-term pressures, but its reactive approach and weak planning fail to deliver sustained improvement or ensure it can meet future demand

Cancer improvement plans

12 The Health Board's Cancer Strategy (2023–28) aligns with national expectations and sets out high-level priorities. However, the strategy does not include specific actions, milestones, or clear accountability arrangements. As a result, there is limited evidence that the strategy drives improvement.

13 The Health Board does not have a cancer improvement plan to support its long-term goals or drive lasting improvement in Single Cancer Pathway (SCP) performance. Instead, it is relying on its Annual Plan 2026–27, which on its own is not enough.

14 The Annual Plan for 2026–27 sets out the Health Board's main priorities, including improving cancer performance, redesigning care pathways, and strengthening team working. These priorities align with national expectations, including the All-Wales Cancer Improvement Plan.

15 However, recovery plans remain high-level. They lack clear ownership, timescales, and measurable outcomes. Links to performance improvement are weak.

16 Actions in the Annual Plan 2026–27 focus on short-term measures, such as extra clinics and overtime, rather than changes that support lasting improvement. There is also limited evidence that planning draws on learning from previous improvement work or best practice.

17 The Annual Plan for 2026–27 does not explain how the Health Board will meet the Suspected Cancer Pathway (SCP) target. It does not show how the Health Board will manage rising demand and treatment costs. It also lacks detail on the staff, funding, systems, and facilities needed. Actions to reduce cancer inequalities are not defined in service plans.

18 The Health Board does not expect to achieve the national SCP target until quarter 4 of 2026–27. However, the Health Board has not made sufficient progress against planned improvements to provide confidence that this aim will be met.

19 Regional partners have arrangements in place to support joint working. However, there is no clear planning approach that sets out how they will respond to expected growth in cancer demand. As a result, it is not clear how future service needs and capacity pressures will be managed across the region.

Cancer intelligence and data

20 The Health Board needs to strengthen how it uses cancer data and intelligence. The Health Board's current use of data is reactive, as it focuses on monitoring day-to-day service pressures rather than supporting planning to sustainably meet future demand.

21 There is little evidence that the Health Board is using data to forecast demand, plan capacity, or support medium-term decisions. This could make it harder to achieve the SCP target and directly affect patient outcomes.

22 The Health Board reviews a wide range of data, including referral numbers, tumour site performance, waiting list backlogs, and reasons for SCP breaches. However, delivery teams do not make enough use of outcome data to guide decisions or improve services. They also do not use data effectively to plan medium-term and long-term capacity. As a result, the focus remains on meeting cancer targets rather than improving patient outcomes. The use of patient experience data in cancer planning is also inconsistent.

Supporting fragile services

23 The timeliness of cancer treatment depends on the type of cancer a patient has. Most patients waiting longer than 62 days on the SCP are in breast, urology, and gastrointestinal pathways.

24 The Health Board knows which cancer pathways are fragile. It uses data, tumour-site reviews, and escalation routes to spot risks and take action. Actions include changes to pathways, extra capacity, and workforce adjustments to reduce pressure. There are some signs of improvement in specific areas. For example, changes to demand and capacity planning and pathway management in dermatology improved performance in the short-term.

25 However, there is little evidence that these actions lead to lasting improvement. While the Health Board responds quickly to fragile services, most of the actions are short-term and focus on managing pressure, rather than fixing the root causes. Performance reports do not clearly show if the changes are leading to improved performance over time. As a result, overall performance remains below the SCP standard and varies across tumour sites.

26 Diagnostic capacity limits progress against the SCP target. The main pressures are well known. These include rising demand, limited diagnostics, workforce gaps, and capacity pressures in regional services.

27 The Health Board has clear arrangements to manage these risks. Teams meet regularly through operational groups, tumour-site reviews, and Cancer Delivery Group meetings. These forums help identify fragile services and focus action. There is a strong focus on the highest-risk areas.

28 Cancer is a priority for regional working. The Health Board discusses issues that it cannot resolve locally with its partners through regional planning forums. Regional cancer service models are also being developed, including shared workforce planning, outreach services, and joint multidisciplinary team working. Regional partnerships are still developing but do not yet show clear benefits.

Financial and resource planning

No clear long-term plan, weak coordination, and rising demand and costs limit progress, reducing confidence that cancer services will improve performance or meet future needs.

Funding plans

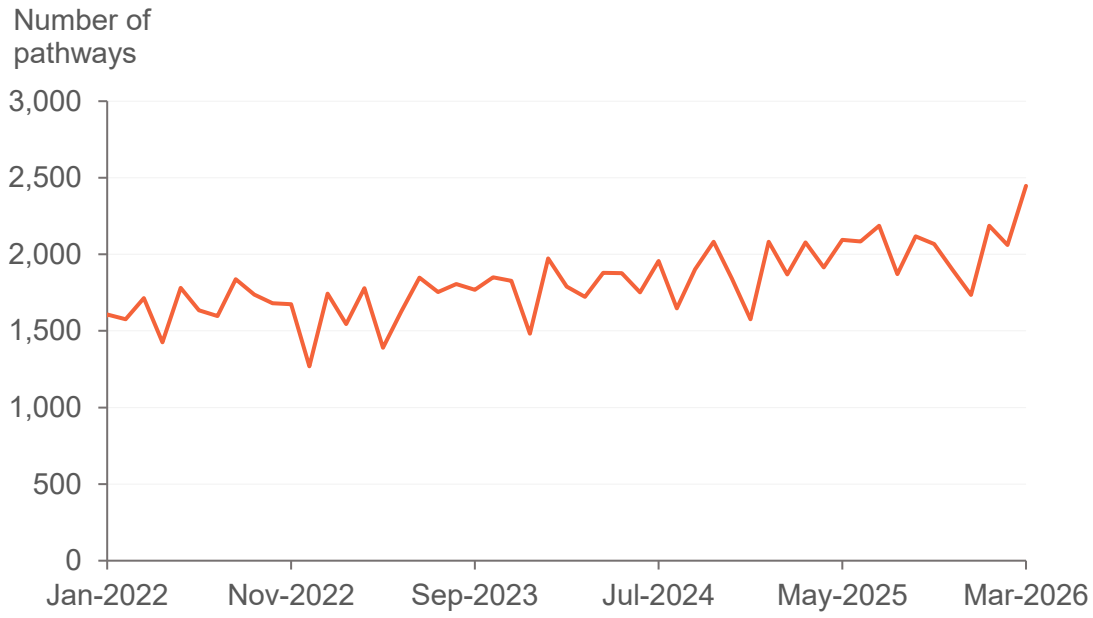
29 There is no single, costed plan for cancer delivery or recovery. It is not clear if all planned improvements are fully funded. Without a clear and costed plan, the Health Board cannot define the level of investment needed to improve services and meet cancer standards and targets. It also does not give assurance to the Board that all planned improvements needed to meet targets are affordable.

30 The Health Board considers cancer costs as part of its overall financial planning. However, the Annual Plan 2026–27 does not set out the current or projected cost of cancer services, despite rising demand and treatment costs.

31 Finance and Performance Committee papers focus on the wider financial position and provide limited information on cancer service costs and sustainability. As a result, the Health Board cannot clearly demonstrate how it plans to meet future demand and deliver its cancer priorities.

32 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This illustrates an ongoing increase through the period. There has been a notable increase in referrals between 2022–23 and 2025–26 in skin (+49%), head and neck (+38%), upper gastrointestinal (+32%), and urological (+26%) tumour sites.

Exhibit 1: newly opened suspected cancer pathways, Cardiff and Vale University Health Board, January 2022 to March 2026 (number)

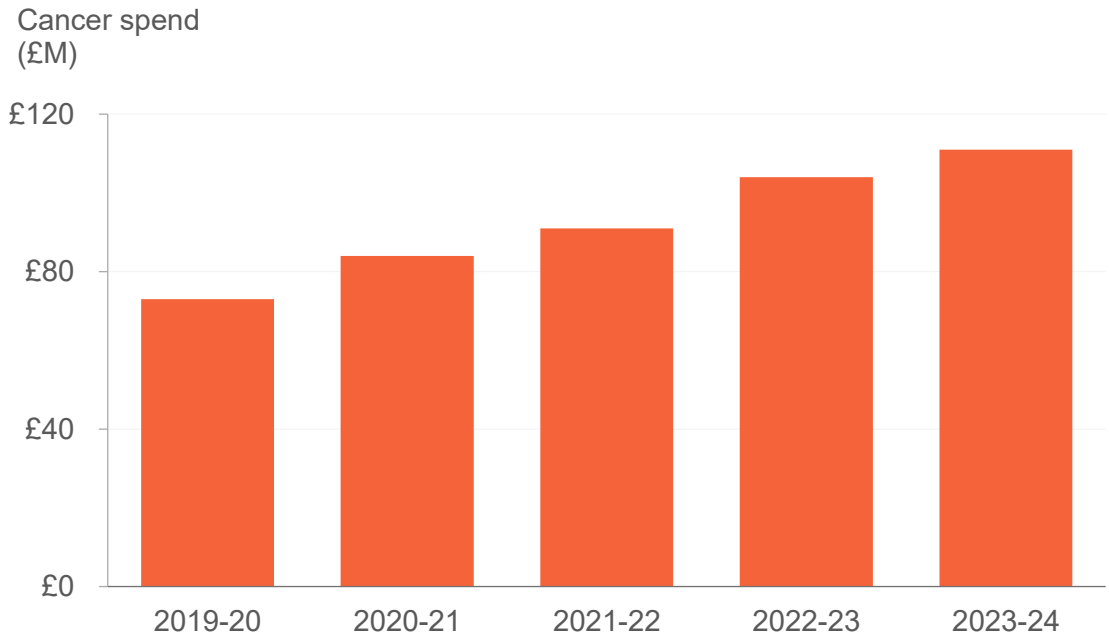


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient died. Note that patients can be on more than one pathway.

33 Cancer care costs have increased faster than inflation. This makes effective planning and cost control increasingly important. **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board's cancer spending rose by around 28% above inflation[1]. Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, the Health Board's spend rose from £17 million to around £25 million[2,3]. This is about £4 million more than if costs had increased in line with inflation (in 2024–25 prices).

Exhibit 2: actual cancer services actual spend, Cardiff and Vale University Health Board, 2019–20 to 2023–24, (£million)



Source: Audit Wales analysis of the Health Board's data, sourced from the Welsh Government

[1] Inflation is calculated using 2023–24 as a baseline and HM Treasury inflation data.

[2] Some speciality medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.

[3] Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

34 **Exhibits 1** and **2** broadly show that increases in cost align to increased new demand. However, cost growth is exceeding inflation and needs to be planned. The Annual Plan 2026–27 does not set out the costs for cancer services. While the Health Board includes cancer costs within divisional budgets, it cannot clearly identify the total planned spend on cancer services. As a result, it cannot easily assess whether funding is sufficient to deliver its cancer priorities and meet future demand. This is a major gap, especially given the scale of cancer services, increasing demand, and ongoing financial pressures, including high-cost treatments and drugs.

Wider resourcing requirements

35 The Health Board clearly understands its workforce pressures. These include vacancies, skills shortages, and limited capacity. Pressures are greatest in diagnostics, such as endoscopy and radiology, and in tumour sites including breast, urology, and gastrointestinal services.

36 The Health Board manages these pressures through regular operational meetings, tumour site reviews, and Cancer Delivery Group oversight. These forums help teams identify risks and resulting actions.

37 The Health Board's workforce planning focuses on addressing current challenges. Staffing gaps in areas such as breast radiology, urology, and gastrointestinal services are monitored and managed through specialist recruitment, pathway redesign and, where possible, additional staffing.

38 Workforce gaps remain and are expected to continue. There is no clear cancer workforce plan. As a result, workforce planning focuses on short-term fixes rather than building sustainable capacity to meet the suspected cancer pathway target.

39 The Health Board recognises the importance of its estate. However, there is no clear estates strategy showing how it will sustainably meet cancer service estate needs.

40 Equipment risks are recognised, but planning to address them is limited. The Health Board does not have clear cancer specific plans for equipment maintenance, replacement, or investment. Key equipment, including endoscopy, is ageing and requires significant investment. While the Health Board makes some individual investments, it does not plan for future demand growth.

41 Cancer services face significant digital challenges. Current systems support basic patient tracking and day-to-day oversight, but there is a heavy reliance on manual data entry into Excel spreadsheets. As a result, real-time tracking of cancer performance is constrained.

42 Automation of data collation is limited, and systems do not integrate well with national platforms or partners. These issues limit visibility across the patient pathway, and data availability delays lead to delayed responses to problems.

43 Digital in the main supports day-to-day tracking, rather than service transformation. The use of Artificial Intelligence to support cancer services is in its infancy across the health sector. However, the Health Board could consider how technology could improve outcomes for patients and drive service efficiencies.

Cancer prevention and population screening

The Health Board is not maximising the benefits of cancer prevention or using data effectively to take targeted action and improve screening uptake

44 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. Even a modest reduction would release significant capacity and reduce costs. For context, if the Health Board prevented just 20% of cancers, it could save around £2.2 million[4] in bed days. **Exhibit 3** shows the potential gains if the Health Board successfully implemented an effective cancer prevention strategy.

[4] Based on 2024-25 activity data, the most recent financial data.

Exhibit 3: potential capacity gains from cancer prevention, Cardiff and Vale University Health Board, based on 2024–25 activity.

	2024–25 actual	-10% reduction	-20% reduction	-38% reduction
Finished consultant episodes	**10,054**	**9,049** (1,005 reduction)	**8,043** (2,011 reduction)	**5,610** (4,444 reduction)
Admission episodes	**9,730**	**8,757** (973 reduction)	**7,784** (1,946 reduction)	**5,429** (4,301 reduction)
Bed days	**22,374**	**20,137** (2,237 reduction)	**17,899** (4,475 reduction)	**13,872** (8,502 reduction)
Bed day cost savings		(**£1.1** million)	(**£2.2** million)	(**£4.2** million)

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales - 'Headline Figures' and 'Primary Diagnosis Datasets' for Welsh providers

Notes:

1) The analysis outlines the broad impact of a 10%, 20%, and 38% reduction in cancer cases, based on 2024–25 activity levels.

2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our 2025 National Cancer Services Report.

Public health risk assessment

45 Population health intelligence is well developed, but it is not being used by the Health Board to drive large-scale cancer prevention initiatives.

46 The Health Board uses a wide range of public health data to understand cancer risk. This includes data on smoking, obesity, alcohol use, and vaccination. It also looks at differences by age, gender, deprivation, and location. This helps the Health Board understand where cancer risk is higher and where inequalities exist.

47 This data is used by the Health Board to support its targeted prevention work. For example, smoking cessation and vaccination programmes focus on areas of highest need. This shows a clear understanding of risk and variation across the population.

48 The Health Board understands key risk factors, including population growth, ageing, and inequalities. However, it does not sufficiently use population health data to inform cancer prevention planning and prioritisation. Financial constraints also limit prevention activity. This reduces the scale of prevention work and makes it harder to maintain in the long term.

49 There is also little evidence that population health data shapes service design, cancer service planning, or future demand modelling.

Approaches to improving population lifestyles

50 The Health Board delivers a range of programmes to promote healthy lifestyles and reduce cancer risk. However, their overall impact is limited.

51 The Annual Plan 2026–27 includes prevention at a strategic level. The plan focuses on improving population health and reducing inequalities, such as vaccination and screening uptake. However, it gives only a high-level view of prevention and lacks detail on cancer specific actions.

52 The Health Board takes part in national prevention programmes, such as smoking cessation and healthy weight schemes. These shape local prevention work and help direct resources to where they are most needed. There is also targeted local activity, including outreach and adapted approaches to improve access for seldom heard groups.

53 Despite this, funding challenges limit the scale and effectiveness of these programmes. As a result, current activity is unlikely to deliver population-level change. In addition, the Health Board should be doing more to learn from previous prevention work to improve future delivery.

54 The Health Board monitors preventative activity and reports on these in Board and performance reports. This provides an understanding of trends and highlights where improvement is needed. However, the Health Board needs to consistently review outcomes data to understand the impact of programmes over time.

Targeted prevention and population screening

55 The Health Board has clear referral routes for patients whose cancer is identified through national screening programmes. However, it does not routinely hold or use screening uptake data, which limits its ability to understand participation patterns, identify groups less likely to attend, and take targeted action to improve uptake. Better use of screening data would help identify non-attendance and address barriers to engagement.

56 Performance data also shows that the timeliness of screening services are negatively impacting on overall timely diagnosis and treatment in some areas, particularly for bowel cancer pathways.

57 The Health Board uses population data to target HPV vaccination uptake, including mobile services for Gypsy, Roma and Traveller communities. This shows a proactive approach to improving access. HPV uptake is close to the Wales average, although there remains scope to increase uptake further to maximise protection against HPV-related cancers.

Cancer leadership and oversight

Operational leadership supports short-term improvement, but strategic oversight of cancer services needs strengthening

Managerial leadership

58 The Health Board has clear executive and operational leadership for cancer services. The Chief Operating Officer has overall responsibility, supported by a Cancer Manager who oversees day-to-day performance. Senior managers make decisions on priorities and spending within agreed limits. The Chief Operating Officer and senior leaders support timely decision-making when needed. This includes agreeing additional clinics and other short-term actions to manage performance pressures.

59 There is no current Cancer Board. A similar group operated previously, bringing together managers and executive leads, but it is no longer active. This reduces cross-organisation coordination and focus on long-term improvement. Establishing a Cancer Board which included staff, primary care, third-sector, and patient representatives, could help the Health Board promote openness and joint working to solve problems.

60 Overall, leadership is strongest at an operational level. Teams work well together to manage immediate pressures. Regular meetings and tumour-site reviews help them monitor performance and waiting lists and take swift action when needed. However, the focus on day-to-day pressures limits the capacity to develop and implement longer-term changes that could improve access and support future service demand.

61 Regional working and leadership are essential to make sure that patients get the right cancer care at the right time. In South-East Wales, health boards plan and deliver many parts of the cancer diagnosis and treatment pathway. But they also commission and fund Velindre University NHS Trust to provide non-surgical specialist cancer services[5] for most patients.

62 The Health Board participates in regional arrangements to improve cross-boundary working. While these arrangements demonstrate a shared commitment to addressing workforce and service sustainability challenges, progress in delivering the agreed regional workplan has been limited. Consequently, there is no clear evidence that regional collaboration has yet translated into improvements in SCP performance or timely access to cancer services.

Oversight and scrutiny

63 Cancer governance arrangements are in place, but they are not brought together in a clear cancer-specific framework. There is no single group that brings together clinical, operational and senior leaders to oversee cancer services.

64 Wider governance arrangements do not consistently drive action or support effective challenge. The Health Board has not appointed a clinical lead for cancer services, limiting clinical input into decision-making. As a result, accountability for cancer improvement is unclear.

65 The Board receives regular updates on cancer performance through the Integrated Performance Report. The report includes performance against the target for 75% of patients to start treatment within 62 days of cancer suspicion. The report also includes information on backlog levels, key risks, planned actions, and progress. This helps keep Board members informed about SCP performance and wider system pressures.

[5]Including radiotherapy, chemotherapy, and other systemic anti-cancer treatments (SACTs).

66 However, the reports do not provide consistent or comprehensive information on tumour-site performance, backlog recovery, or cancer outcomes. While some tumour-site performance is reported, it is not presented in a consistent way across reports. This is important because overall performance can mask variation between cancer pathways. As a result, the Board may find it harder to identify areas of sustained underperformance and assess whether improvement actions are delivering the intended benefits.

67 The Board shows active engagement and challenges key areas of underperformance, including cancer pathways and capacity pressures. Members ask relevant questions and request further updates, which supports oversight of performance. However, Board scrutiny remains high-level and focuses on system-wide issues rather than variation within pathways. While the Board approved the Cancer Strategy, there is limited evidence of ongoing monitoring or delivery tracking.

Cancer performance

The Single Cancer Pathway target is not being met, and its current actions are not effective in reducing waiting times or improving outcomes

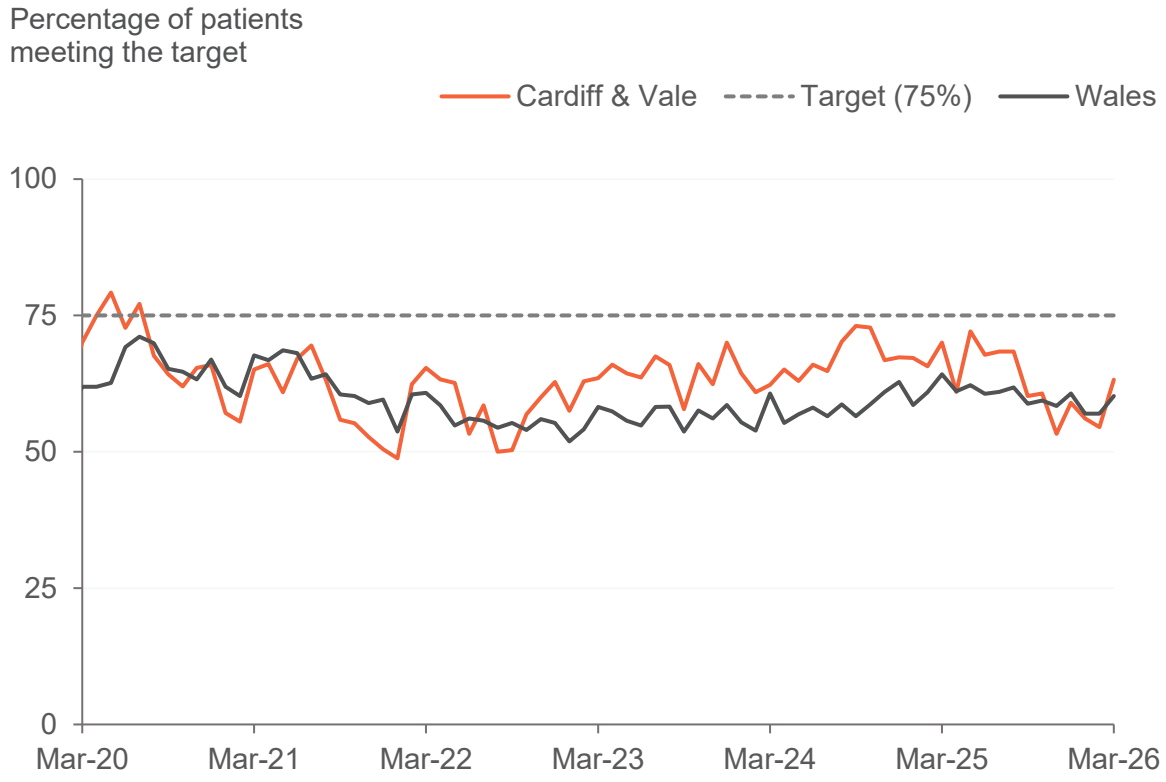
62-day cancer performance

68 The Welsh Government target is for 75% of patients to start their first treatment within 62 days from the point where cancer is suspected.

69 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.

70 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has substantially increased. Despite this increase over the last four years, the Health Board has done well to ensure performance has not deteriorated. However, the Health Board's performance is falling well short of meeting the national cancer target (**Exhibit 4**), despite broadly reflecting or occasionally exceeding the Welsh average. It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

Exhibit 4: patients meeting the 62-day cancer treatment target, Cardiff and Vale University Health Board, March 2020 to March 2026 (percentage)



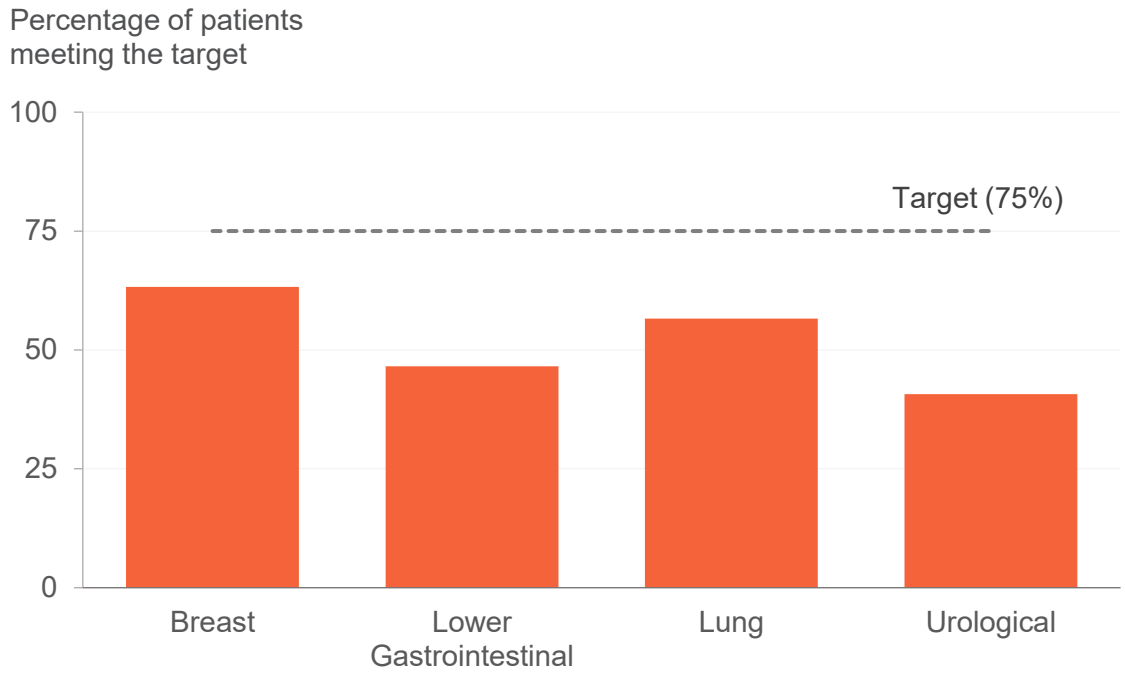
Source: Audit Wales analysis of Digital Health and Care Wales

Note: The data will include patients that waited more than 62 days to be told they do not have cancer, as well as those starting cancer treatment

71 Overall performance also hides large differences between sex and tumour types. In most months during 2025-26 a higher proportion of men than women waited more than 62 days. At its extreme, in December 2025, 73.7% of women started treatment within 62 days. In that same month, that figure for men was 48%.

72 **Exhibit 5** shows performance across four common cancer tumour sites and highlights significant concerns about urological and lower gastrointestinal cancer waits. Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target, with 95% of patients starting their treatment within 62 days.

Exhibit 5: patients meeting the 62-day cancer treatment target by tumour site, Cardiff and Vale University Health Board, 12-month average during 2025-26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data. The data will include patients that waited more than 62 days to be told they do not have cancer, as well as those starting cancer treatment.

Notes:

1. The data shown average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. Note: The data includes patients who started treatment and confirmed that that they do not have cancer.

Impact of action to improve cancer services

73 The action taken by the Health Board is helping to manage some short-term risks, and performance is closely monitored by leadership. However, this has not led to significant improvement in overall performance or addressed underperformance in some tumour sites. As a result, the focus remains on managing immediate pressures rather than improving services for the longer term.

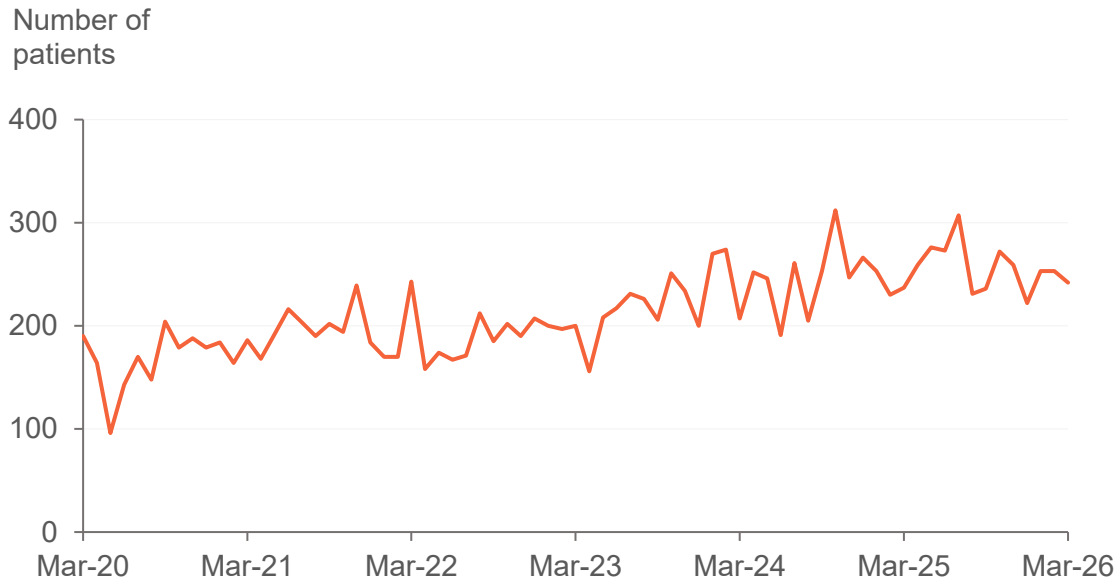
74 The Health Board understands the main causes of poor performance, including rising demand and workforce pressures. Current actions focus on managing these pressures. These include targeted recruitment in key specialties, short-term workforce changes, new roles to support improvement work, and extra clinics and weekend working.

75 Teams respond proactively to performance pressures and adapt their actions to support delivery. They implement a range of improvements, including pathway redesign, extra clinics and sessions, and targeted action in fragile service areas. These actions help manage demand, improve patient flow, and support short-term performance recovery.

76 However, there are no clear milestones or outcome measures linked to these actions. As a result, it is not clear if these actions deliver lasting improvement or achieve the intended results. Overall, improvement activity is visible but does not yet provide assurance that services can maintain progress and meet the 62-day SCP standard.

77 Performance against the 62-day target shows that current actions are not yet having enough impact on improving capacity. The number of patients starting treatment each month has increased gradually since 2020. However, overall activity is not rising at the pace needed to deliver consistent improvement against the 62-day standard (**Exhibit 6**).

Exhibit 6: cancer patients starting treatment each month Cardiff and Vale University Health Board, March 2020 to March 2026 (number)

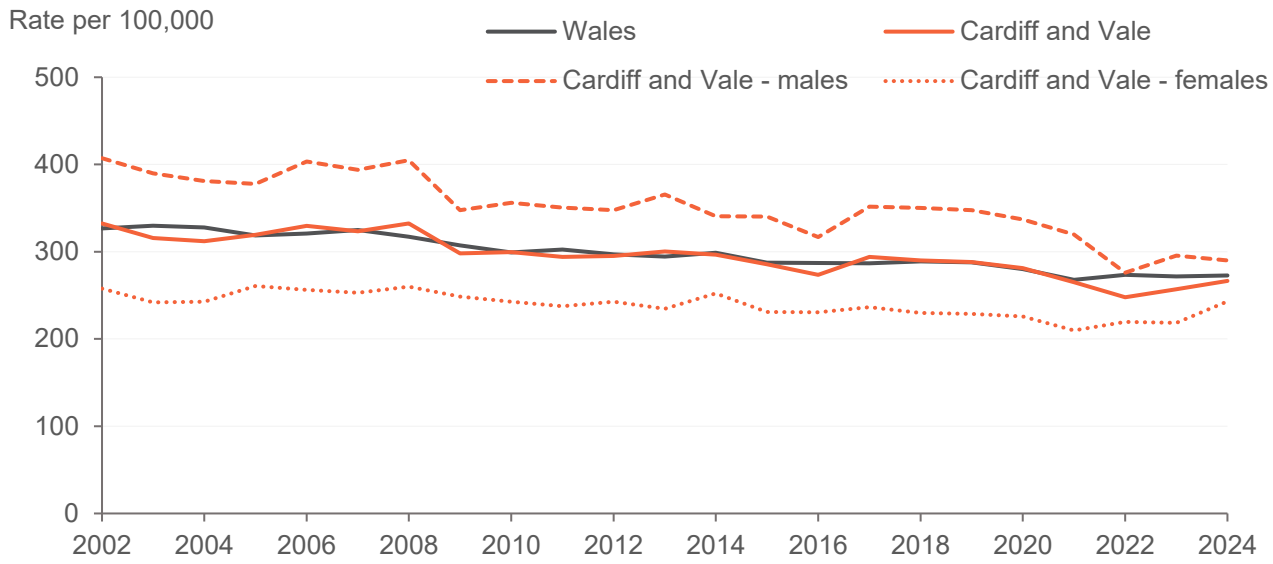


Source: Audit Wales analysis of Digital Health and Care Wales data.

Improving cancer outcomes

78 The Health Board does not use outcomes data effectively to drive improvement. Outcomes data are not reported to senior leaders or the Board. This limits oversight of patient outcomes, and the impact of improvement activity to make related improvements. Also, there is little evidence that services use outcomes data to inform priorities, recovery planning, or system-wide improvement. However, plans are in place to introduce outcome and experience measures.

Exhibit 7: one-year cancer mortality, Cardiff and Vale University Health Board 2002–2024 (rate per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

79 Analysis of one-year cancer mortality data from 2002 to 2024 (**Exhibit 7**) shows a consistent reduction in mortality over the last 22 years. While the Health Board's cancer mortality rate is in line with the Wales average, outcomes for males remain worse than for females, although improving.

80 While long-term trends are improving, our national report found that cancer outcomes in Wales remain poor compared to other countries. The Health Board needs to focus more on outcomes to develop targeted and prioritised improvement actions.

Recommendations

Cancer services planning

R1 The Health Board should urgently develop a costed cancer improvement plan, to ensure sustainable delivery of the cancer strategy as demand increases. The plan should:

- be based on current and projected future demand;
- include capacity plans aligned to projected demand;
- be costed, at a minimum, over the medium-term (three to five years);
- be supported by resource plans, including: finance, workforce and infrastructure (estates, equipment);
- include specific, measurable, achievable, relevant and time-bound (SMART) improvement actions and milestones;
- include clear arrangements for monitoring delivery, evaluating impact, and reporting progress against planned actions and outcomes; and
- be approved by the Board.

(**Paragraphs 13-41**).

Prevention and screening

R2 The Health board should work collectively with other Health Boards and Public Health Wales NHS Trust to agree, as soon as possible, a comprehensive dataset for analysing screening services. This should include:

- Timeliness across each part of the current three national cancer screening pathways and lung screening, once fully rolled out.
- Information on screening uptake rates and variations across population groups, including age, location, sex (where applicable), and ethnicity

(**paragraph 55**).

R3 The Health Board should make better use of screening and population data. It should use this information to identify groups with lower uptake, target support and improve screening rates **(paragraph 55).**

Managerial leadership

R4 The Heath Board should, as a priority, appoint a clinical lead for cancer services to ensure appropriate clinical input in decision making (**paragraph 64**).

R5 The Health Board should urgently re-establish the Cancer Delivery Board to strengthen governance, improve accountability, and drive cancer performance improvement (**paragraph 59**).

Cancer progress reporting

R6 The Health Board should collect and use patient experience and outcomes data as soon as possible to inform cancer planning (**paragraph 78**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience. We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria.

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?

- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Managerial cancer lead;
- Executive lead for cancer services;
- Clinical nurse for cancer services; and
- Director of Public Health.

We also held a focus group with the operational specialty management leads for lung, lower gastrointestinal, urological, and breast tumour sites.

2 Key terms in this report

Term	Description
62-day Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes.
Colonoscopy	Endoscopic examination of the large bowel to diagnose/biopsy lower GI cancers.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.

Term	Description
HPV vaccine	The HPV vaccine helps protect against the human papillomavirus (HPV), a common virus that can cause several types of cancer, including cervical cancer. It works by helping the body's immune system prevent HPV infection.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Seldom heard	Seldom-heard groups are patients whose voices are often missed when services seek feedback, make decisions, or plan improvements.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., chemotherapy, targeted and immunotherapies) to treat cancer
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

3 Management response form

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should urgently develop a costed cancer improvement plan, to ensure sustainable delivery of the cancer strategy as demand increases. The plan should: • be based on current and projected future demand; • include capacity plans aligned to projected demand; • be costed, at a minimum, over the medium-term (three to five years); • be supported by resource plans, including: finance, workforce and infrastructure (estates, equipment); • include specific, measurable, achievable, relevant and time bound (SMART) improvement actions and milestones; • include clear arrangements for monitoring delivery, evaluating impact, and reporting progress against planned actions and outcomes; and • be approved by the Board.	A costed cancer plan will be created that aligns with the current Strategic Plan for Cancer. It will include the appropriate demand and capacity plans along with supporting infrastructure and workforce plans. This will be done to the best of our ability given the current digital systems available to us. This will be submitted to the board for approval. The timeline for this action has been chosen to give enough time for the national Cancer Strategy to be released in Feb 2027 and for us to read, understand and align our local plans accordingly.	June 2027	General Manager – Cancer Services

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R2 The Health board should work collectively with other Health Boards and Public Health Wales NHS Trust to agree, as soon as possible, a comprehensive dataset for analysing screening services. This should include: • Timeliness across each part of the current three national cancer screening pathways and lung screening, once fully rolled out. • Information on screening uptake rates and variations across population groups, including age, location, sex (where applicable), and ethnicity.	We will take this collective action through the Cancer Network and NHS Wales Performance and Improvement to ensure we contribute to a national solution.	March 2027	General Manager – Cancer Services
R3 The Health Board should make better use of screening and population data. It should use this information to identify groups with lower uptake, target support and improve screening rates.	Cancer Services within CAV UHB will work with local Public Health teams to maximise the use of population level data to help inform future cancer services including screening rates. This will also form part of a wider UHB structure around cancer than is built on the reinstatement of the Executive Cancer Board.	March 2027	General Manager – Cancer Services & CAV Public Health Consultant

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R4 The Heath Board should, as a priority, appoint a clinical lead for cancer services to ensure appropriate clinical input in decision making.	This process is already under way and the advert is live.	December 2027	Director of Operations for Clinical Diagnostics and Therapeutics, Cancer, Diagnostics and Regional Partnerships
R5 The Health Board should urgently re-establish the Cancer Delivery Board to strengthen governance, improve accountability, and drive cancer performance improvement.	We will re-establish the Cancer Delivery Board in conjunction with recommendation 4 (appointing a clinical lead). We will also have the appropriate workstream structures to support the board.	December 2027	Executives

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R6 The Health Board should collect and use patient experience and outcomes data as soon as possible to inform cancer planning.	We will take advantage of the existing patient experience and outcome data we have available within the UHB to inform cancer planning. We will, where possible, strengthen the information we collect. We will also develop a specific workstream that aligns to the wider cancer governance structure which focuses on patient voice and experience. This will provide valuable lived experience data that can help shape our services and inform our wider cancer plans.	March 2027	Lead Cancer Nurse & wider Cancer Services

About us

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

Archwilio Cymru
Audit Wales

Digital transformation

Cardiff and Vale University Health Board

July 2026

About us

We have prepared and published this under section 61(3) (b) of the Public Audit Wales Act 2004.

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Contents

Audit snapshot

What we looked at

1 We looked at how Cardiff and Vale University Health Board's (the Health Board) approach to digital transformation is supporting service improvement. This included its approach to digital strategy, leadership, and skills development. We also considered how the organisation manages risks around digital infrastructure, cyber resilience, and Artificial Intelligence (AI).

Why this is important

2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.

3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another and organisations must manage ever-growing risks around cyber resilience.

4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

What we have found

5 The Health Board has a clear digital ambition and recognises digital as a key enabler of service quality, safety and sustainability. However, there are areas where greater clarity is needed for some Members of the Board on how this ambition will be delivered. Despite this, the Board shows strong ownership of digital transformation and has put governance arrangements in place to highlight key digital risks and priorities.

6 There is a significant risk that the Health Board will not fully deliver its digital ambitions. This includes an ageing and fragmented infrastructure, and gaps in workforce digital skills. Ongoing uncertainty over the affordability and funding of the five-year Digital Foundations Programme may further constrain delivery.

7 The Health Board broadly understands its main digital, cyber, infrastructure risks and is taking action to improve assurance on these. It is also developing a better understanding of its AI risks. However, current arrangements are not yet effective. As a result, these risks still represent areas of ongoing concern for the Board.

8 The Health Board is committed to using digital to improve patient outcomes and service quality. It understands the importance of digital inclusion and has arrangements in place for clinical engagement. However, approaches to engage staff and service users in the design and adoption of digital projects continue to develop.

9 The Health Board works closely with national and regional partners and is supportive of a Once for Wales approach where these are appropriate. The Health Board has successfully implemented a range of local digital projects over the last few years. However, delays or changes in national programmes and the limitations of its current infrastructure is impacting local delivery and are having a knock-on effect to delivering the Health Board’s digital transformation.

What we recommend

10 We have made eight recommendations to the Health Board which focus on:

- Strengthening strategic delivery and affordability;
- Develop the Board's understanding of digital;
- Improving assurance over digital and cyber risks;
- Establishing a clear approach for Artificial Intelligence;
- Building workforce readiness for digital transformation;
- Having a clear contingency plan for funding its digital transformation;
- Embedding how it works with staff and patients in its digital developments; and
- Reporting on its digital programme benefits.

Key facts and figures

Of the Health Board's workforce of approximately 17,000 staff, only 323 had completed the HEIW Digital Capability Framework self-assessment tool as of November 2025.

Since March 2025, the Health Board has had four reportable incidents to the Cyber resilience unit.

The Health Board is currently at HIMSS EMRAM Level 1, and HIMSS INFRAM level 2 status, indicating very low digital maturity and continued reliance on paper-based processes and fragmented systems.

The Health Board has signed up to Digital Communities Wales Digital Inclusion Charter.

Our findings

Strategy, planning and leadership

The Health Board has a reasonably clear strategic digital approach and oversight. However, the accountabilities of the clinical boards for digital are not fully effective.

Digital strategy and plans

11 The Health Board has a clear understanding of what is needed for its digital transformation. While its five-year Digital Strategy is outdated, the Digital Foundations Programme Roadmap clearly identifies the Health Board's focus for its digital agenda, setting out key digital priorities for the next five years. Through this it seeks to meet its statutory obligations, improve day to day efficiency, effectiveness, improve quality and is central to the delivery of its short- and long-term commitments.

12 The original digital strategy and current roadmap align with the national 'Once for Wales' approach. The roadmap has clear links to the Health Board's Annual Plan and long-term wellbeing strategy, which also brings together the Health Board's medium to longer term financial, estates and workforce aspirations. However, it still needs to align to clinical service priorities. The Health Board plans to update its Digital Strategy. This should further strengthen the link between digital planning and annual planning.

13 The Digital Foundations Programme sets out the Health Board's digital plan. The programme recognises the Health Board's current low levels of digital maturity. It describes a phased approach to renewing infrastructure, improving the way in which systems can work together, building digital skills and aiming to achieve HIMMS EMRAM level 3 maturity within five years. It also sets milestones and key dependencies.

14 Clinicians and senior leaders have effectively supported the development of this programme. A detailed business case supports it which sets out financial and non-financial benefits. These include improving patient safety and clinical effectiveness and reducing variation and inequality in care. The Health Board expects that its Digital Foundations Programme will start this year.

Board ownership of digital transformation

15 The Board shows strong ownership and commitment to digital transformation. It treats digital as a strategic enabler, not just a technical function. The Board understands the scale of the challenge and the key role of the Digital Foundations Programme in supporting safe and effective services. The Digital and Infrastructure Committee supports effective oversight. An Independent Member chairs the Committee, which provides structured challenge and assurance.

16 The Board has held development sessions on digital in the past. However, our Board self-assessment found gaps in some Board Member's knowledge on some specific areas of digital, such as, AI, staff and patient digital engagement and cyber. The Health Board told us it will address these gaps through twice-yearly deep dives on topics such as cyber security and AI at future Board development sessions.

17 The Health Board also continues to take part in the All-Wales Directors of Digital and IM Digital Network meetings. This allows organisations to share learning, good practice, and take part in national digital discussions that support the Health Board's digital transformation.

Roles, responsibilities, and accountability

18 The Health Board has a clear governance framework for digital transformation. At committee level, the Digital and Infrastructure Committee supports a framework for effective accountability. An Independent Member chairs the Committee and provides focused scrutiny of digital strategy, delivery progress, risks, and assurance.

19 Officers provide the Board with sufficient technical and digital advice. The Director of Digital and Health Intelligence is a Board member. The Health Board also has a specific Director role focused on delivering digital transformation. Together, these Directors provide expert advice and leadership on digital.

20 The Board is aware of the Health Board's digital ambitions and constraints. Board papers, committee observations, and interviews indicate that the Board and its committees appropriately discuss digital issues and risks. Reporting on digital sufficiently covers the key risks and initiatives. However, broadening the scope of its digital reporting on progress against its roadmap will strengthen the Board's and committee's oversight of its digital ambitions.

21 Operational roles and responsibilities for digital are still evolving. The Health Board has set up supporting governance groups. This includes forums for technical design, digital and clinical design, cyber security, information governance, and data and intelligence. Once these groups are fully embedded, they should provide the right professional input to decisions and help ensure that leaders consider clinical, technical, and wider risks.

22 The Director of Digital has overall responsibility for the digital strategy. However, responsibility for key aspects of digital is devolved to the clinical boards. There are blurred lines of accountability between the central digital team and devolved responsibilities. The Health Board has acknowledged risks and issues relating to "shadow IT" and locally developed digital solutions in different services. These reflect decentralised decision-making for digital. An Internal Audit review in August 2025 also raised concerns about the roles and responsibilities of Clinical Boards for some digital risks, such as cyber. The Health Board told us it is taking action to address these issues. Until it resolves them fully, this remains a significant ongoing risk.

Identifying and managing risks

While Health Board broadly understands its digital risks, it does not have fully effective controls to address these.

Strategic digital risks

23 The Health Board appropriately recognises digital transformation as a strategic risk featuring prominently on the Board Assurance Framework. The Health Board understands that failing to modernise digital infrastructure would undermine service resilience, clinical safety, and productivity. The digital risk descriptions are clear and are reviewed regularly. However, the mitigating actions depend heavily on the Health Boards future decisions on how its prioritises its investment in digital and access to additional external funding (Paragraphs 40-44). This, in part, limits the Health Board's ability to reduce risk in the short to medium term. As a result, the strategic digital risk remains high despite active oversight.

Digital infrastructure risks

24 The Health Board is aware of its key digital infrastructure risks but has not yet sufficiently resourced the actions needed to fully address these. I Although it does not yet have a comprehensive view of its IT infrastructure and therefore unknown and unquantified risks may exist. Electronic Medical Records Assessment Model (EMRAM) and Infrastructure maturity and adoption Model (INFRAM)[1] assessments confirm very low digital maturity and show that historic infrastructure gaps remain significant. The Digital Foundations Roadmap sets the direction for infrastructure change. However, core systems are ageing, interoperability is limited, and legacy technology remains widespread.

25 The Health Board has developed a plan and prioritisation processes for parts of its infrastructure replacement and upgrade. The Health Board is continuing to implement digital infrastructure projects, such as server replacements and its migration to Windows 11. However, the delivery of its wider ambition for its digital infrastructure is constrained by limited capital and other competing pressures. As a result, infrastructure risks remain, including system outages, performance issues, and inefficiency. Until the Health Board is able to invest in its infrastructure, its ability to reduce infrastructure risk significantly, remains limited.

Cyber resilience

26 The Board views cyber security as a key organisational risk but needs to do more. The Health Board has dedicated cyber leadership, takes part in national cyber arrangements, and has strengthened controls in response to internal audit findings. It also understands its cyber risk exposure and there are regular reports on Cyber to the Infrastructure & Digital Committee. However, legacy systems and workforce pressures increase vulnerability and place additional demands on specialist teams.

27 An Internal Audit review from August 2025 gave limited assurance on aspects of cyber security. It highlighted gaps in authority, capacity, and assurance. The Health Board's rating against the Cyber Resilience Unit's Cyber Assessment Framework is "not achieved". The Health Board's cyber improvement plan is targeted on mitigating its cyber risks and working to address both internal audit and Cyber Resilience Unit actions. However, these findings, alongside infrastructure risks, mean that cyber risk remains high.

28 The Health Board works closely with national NHS cyber expertise, including taking part in resilience exercises. In August 2025, the Health Board achieved a 72% completion rate for staff cyber security e-training. This means that almost a third of staff have not completed the training. The Health Board's cyber team continues to run increasingly sophisticated internal phishing exercises. Recent results show there is still scope to improve.

Artificial intelligence

29 The Health Board's strategy for its approach to AI is still to be developed. The Health Board recognises the potential value of AI, including supporting clinical decision-making, improving efficiency, and reducing administrative burden. However, at the time of our review, the Board had not approved an AI strategy.

30 The Health Board's has emerging governance arrangements for AI, however these are not yet fully effective. AI-related risks are not explicitly recorded on corporate or digital risk registers and clear AI policies and controls need to be developed. The Health Board is aware of examples of where AI is being used in operational practice such as within Robotics and genomics. However, the Health Board's is aware of gaps in its knowledge around AI use and assurance over existing and emerging uses of AI. The Health Board has acknowledged these gaps and has started to address them. However, the arrangements are not yet fully embedded or effective.

Digital skills

The Health Board's approach for understanding and building digital skills leaves it poorly prepared for digital transformation.

Assessing digital skills

31 The Health Board does not know what digital skills staff have. It says these skills are essential to deliver its digital plans. Its strategy documents also note that staff skills are needed for transformation. A recent Internal Audit review reported that 'the Health Board lacks a consistent, coordinated, and role-specific approach to assessing digital literacy and capability across its workforce'.

32 Few staff use HEIW's Digital Capability Framework (DCF). The current DCF measures staff's basic IT capability. By November 2025, only 323 staff out of around 17,000 had completed the DCF self-assessment. This is similar to other health bodies. The Health Board reported that the framework is off-putting to many staff due to its length and the number of questions, creating a high barrier to entry for busy clinical staff. However, the response is too small to give a useful starting point and the focus of the DCF does not assess the digital skills gaps for wider digital transformation. The Board therefore has a limited view of how ready staff are for current and future digital initiatives.

Developing digital skills and capacity

33 The Health Board's current digital training does not sufficiently support its digital plans. It offers some training, such as national learning resources, induction, and role-specific training linked to system rollouts. However, it does not have a single, funded programme for staff digital skills. There is also a recognition that there is a tension between prioritising other mandatory and professional training and undertaking digital training which is currently not mandated.

34 The Digital Foundations Programme states that staff capacity and skills are critical to its success. It highlights a need for a more structured approach to developing digital skills. However, we saw limited evidence that this is happening in practice. This creates a risk that staff readiness could fall behind digital programme delivery. If this happens, new systems may go live but deliver fewer benefits.

35 The Health Board has many vacancies in digital and technical roles. This includes specialist posts that support delivery, resilience, and cyber security. Vacancies reduce capacity and increase reliance on a small number of key staff, affecting service resilience. Senior leaders said it is becoming harder to recruit and keep digital specialists because commercial sectors offer strong financial incentives.

Collaboration and involvement

The Health Board understands the importance of digital exclusion and staff engagement to support digital developments. However, it needs assurance that its approach is effective.

Reducing digital exclusion

36 The Health Board understands the risks of digital exclusion. It has made digital inclusion a key priority in both its Digital Strategy and the Digital Foundations Programme. This will support its wider plans for digital change and service modernisation. The Health Board has also signed the Digital Communities Wales Digital Inclusion Charter. This supports its stated ambition on digital inclusion.

37 The Board discusses digital exclusion and considers it in impact assessments for digital projects. However, the Health Board is not consistently assessing or reporting on the impact of its digital inclusion work. This means that it cannot be fully assured that it is not disadvantaging some groups of patients and service users.

Staff and service user involvement

38 The Health Board values staff and service user input in digital transformation. It has involved staff and service users in several digital initiatives. Where this has happened, it has improved usability, clinical relevance, and acceptance of digital tools. It also has a Health Board-wide initiative which is not focused only on digital, but it lets staff share ideas and raise digital and other issues with senior management.

39 The Health Board has a governance framework to involve clinicians in digital work. The Clinical Design Authority Group provides a structured way to do this. The Health Board is working to embed a more formalised approach to how it works with service users to design digital systems. However, until this approach if used consistently across all digital developments there is a risk that digital tools may not deliver the expected benefits because people do not adopt it fully or find it hard to use.

Using digital developments to support service transformation

The Health Board is implementing local and national digital solutions. However, uncertainty over digital funding and reliance on delivering benefits may undermine its digital transformation ambitions.

Investment in digital transformation

40 Funding for the Health Board's main digital programme is not yet confirmed. The Digital Foundations Programme is its main investment plan for digital transformation over the medium term. Delivery depends on accessing additional Welsh Government capital funding or funding the programme from existing resources. At the time of our review, Welsh Government had not approved the funding and there were concerns over the Health Board's ability to self-fund the programme. Exhibit one shows that the Health Board has marginally increased its revenue spend on digital over the last three years. During this same period its capital spend on digital has almost doubled. However, uncertainly over significant future digital investment creates major challenges about the scope, pace, and sequence of delivery.

41 The success of the Health Board's Digital Foundations programme is based on fully delivering the agreed benefits. Current estimates suggest Welsh Government will be asked to fund £25 million of capital, plus around £9 million of capital depreciation charges. The Health Board would then fund the associated revenue of around £26.67 million over five years. However, these estimates may change as the Health Board is continuing to move towards cloud based and Software as a Service models which are traditionally funded out of revenue.

42 It is positive that the Health Board is estimating the benefits of its plans. The five-year programme currently forecasts £23.8 million of benefits. Of this, £8.01 million is cash releasing and £15.76 million is non-cash releasing.

43 The Health Board says its benefits forecasts are realistic. However, if it cannot deliver the agreed benefits, later phases of the programme may become unaffordable. This risk is higher where financial benefits are reliant on workforce reduction through digital efficiencies.

44 Programme success is inherently reliance on sufficient funding. The Health Board is considering contingency options if it does not secure full funding for its Digital Foundations Programme. These options include re-phasing delivery, reducing scope, and working with clinical Boards to identifying additional benefits from those in the original benefits plan. Contingency planning is important. However, delays in starting the programme could also extend reliance on legacy systems and increase operational fragility and cyber risk.

45 The Health Board has a clear and logical process to approve digital investment. Proposals are scored and ranked, then reviewed in turn by key groups and committees before final Board approval. This process provides strategic oversight of digital investment.

46 We intended to set out planned digital investments. However, we were unable to assess the future digital revenue and capital spend in more detail as the Health Board did not provide the information requested. Therefore, we could not fully evaluate future digital funding risks.

Exhibit 1: Annual capital and revenue investment in digital (2023–24 to 2025–26)

Financial Year	Capital (£m)	Revenue (£m)
2023-24	4.6	19.4
2024-25	5.8	23
2025-26	8.5	24.3

Source: Health Board

Local and regional digital projects

47 The Health Board is progressing several local and regional digital projects to address service needs and operational challenges. For example, Electronic Prescribing and Medicines Administration is now live in 70% of hospital wards. The Health Board is also developing a regional shared care record (for direct care) with Cardiff Council and the Vale of Glamorgan Council. It is also supporting work to improve cardiac services in South Wales, with a dedicated digital workstream. These projects show innovation and a focus on local priorities. In some cases, they have delivered clear local and regional improvements such as the more efficient sharing of information between partners.

48 The Health Board gives the Digital and Infrastructure Committee regular updates on regional digital progress. These updates include a RAG summary of national and regional projects in the Digital Roadmap and Work Programme. They also summarise progress against plan and set out key steps taken to date. The Health Board has committed to ongoing engagement with Digital Health and Care Wales as regional ways of working develop.

Adopting national digital systems

49 The Health Board works closely with key digital partners. This includes Digital Health and Care Wales, Health Education and Improvement Wales, Welsh Government, and the Clinical Networks within NHS Performance and Improvement. It supports the adoption of national digital systems and the *Once for Wales* approach. The Health Board has engaged with national partners to align its plans. This supports interoperability and reduces the risk of duplication. Senior management also said closer working with English health bodies could help identify and adopt good digital practice.

50 The Health Board is concerned that national systems create dependencies outside its direct control. Delays or changes to national programmes can affect local delivery. This is a particular issue because the Health Board has low digital maturity and still relies on legacy systems. Whilst progress on national programmes is reported to the Infrastructure & Digital Committee, there is limited additional commentary and assurance provided over the effectiveness of these.

Evaluating digital solutions

51 The Health Board's approach to evaluating digital solutions is still developing. It recognises that evaluation is important. In some cases, it has set expected benefits and tracked progress during implementation.

52 The Digital Foundations Programme includes a clear framework for benefits and evaluation. It covers cash-releasing and non-cash-releasing benefits. It also covers qualitative benefits, including patient safety, staff experience, information governance, and service resilience. It is important for the Health Board to start and then report progress on this work so it can provide assurance that its digital investments are making a difference and delivering value for money.

Recommendations

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

Recommendations

R1 The Health Board should ensure when it refreshes its digital strategy there is a clear relationship between this and the clinical services and workforce strategies that are also in development. (**Paragraph 12**)

R2 The Health Board should:

R2.1 Build a clear understanding of where there are gaps in Board Members knowledge of the Health Board's digital arrangements.

R2.2 Design specific Board development workshops and training to fill these gaps. (**Paragraph 16**)

R3 The Health Board should strengthen its cyber security assurance, addressing the specific weaknesses identified through recent external assessments. (**Paragraph 27**)

R4 The Health Board should quickly develop a clear AI strategy and ensure this is underpinned by clear governance and risk management arrangements. (**Paragraph 30**)

R5 The Health Board should strengthen its approach to digital skills by:

R5.1 Developing a clear understanding of any gaps in the digital skills of its workforce; and (**Paragraph 32**)

R5.2 Developing a funded, structured and organisation-wide approach to addressing the digital skills gaps. (**Paragraph 33**)

R6 The Health Board should develop a clear financial contingency plan for funding its digital transformation ambitions if additional Welsh Government funding is unavailable. (**Paragraph 40**)

R7 The Health Board should ensure that:

R7.1 It provides clearer assurance to Board on if its digital developments are positively impacting digital exclusion. (**Paragraph 37**)

R7.2 Its co-production approach to digital developments is consistently used. (**Paragraph 39**)

R8 The Health Board should ensure that at least twice a year it reports progress on delivering the agreed benefits of its digital programme to the Infrastructure and Digital Committee. (**Paragraph 52**)

Appendices

1 About our work

Scope of the audit

The goal of this audit is to find out if the Health Board is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership, and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a well-led and appropriately resourced approach to digital transformation?
- Is the Health Board developing the digital skills, capacity, and capability of its workforce?
- Does the Health Board have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Health Board engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Health Board actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.
- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked the Health Board to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and Digital and Infrastructure committee papers and minutes.
- Key strategies and plans, including the Digital Strategy, Digital Foundations Programme Papers and Annual Plan.
- Key risk management documents, including the Board Assurance Framework.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chief Executive
- Director of Digital and Information
- Director of Digital Transformation
- Independent Member – Chair of Digital and Infrastructure Committee
- Cyber Security Manager

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

- Digital and Infrastructure Committee.

2. Key terms in this report

Term	Description
Cloud	IT services (such as software, storage, or computing power) that are delivered over the internet from remote data centres instead of on-site infrastructure.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Digital Inclusion Charter	The Digital Inclusion Charter for Wales is a national set of commitments that organisations sign up to in order to actively support and promote digital inclusion across Wales.
Electronic Prescribing and medicines administration (ePMA)	A system in its hospitals, designed to improve patient safety through better documentation, streamlined workflows, and more efficient access to medication records as part of NHS Wales' Digital Medicines Programme.
EMRMA	Electronic Management Records Maturity Assessment – provides an assessment of where Health Bodies stand on full use of your patient health records.
HEIW's Digital Capability Framework	A national model outlining the digital skills, behaviours and confidence health and care staff need, organised into six capability domains with a self-assessment tool for development.
HIMMS	Healthcare Information and Management Systems Society – a global, non-profit organisation dedicated to improving health quality, safety, and cost-effectiveness

	through the best use of information technology and management systems.
INFRAM	Infrastructure maturity and adoption Model, designed to assess requirements for safe and effective care deliver.
Integrated Medium Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
My Medical Record	System allows patients access to results quickly, as well as access to records and clinic appointments.
Once For Wales	National approach in NHS Wales where a digital system, process or standard is designed, procured and implemented once at a national level, rather than each Health Board creating its own version.
OpenEyes	Electronic patient record (EPR) system designed specifically for ophthalmology services.
Planned Care Programme	The NHS Wales programme focused on reducing long waits, improving outpatient and theatre efficiency, and ensuring timely treatment—especially for cancer and the longest-waiting patients—through pathway optimisation, day-case expansion, and improved scheduling.
Shadow IT	Shadow IT refers to any software, hardware, or technology service used within an organisation without the knowledge, approval, or oversight of the IT department.
Six Goals Programme	A national NHS Wales transformation framework for urgent and emergency care, structured around six goals covering admission avoidance (Goal 1), front-door

	assessment and flow (Goals 2–4), and effective discharge and recovery (Goals 5–6).
Software as a Service	Software that is accessed over the internet rather than installed locally, with the supplier responsible for hosting, maintenance, updates, and security.
Strategic Risk Register	The Strategic Risk Register sets out the risks linked to the organisation's strategic objectives, and the controls and assurances in place to manage those risks.
Cloud	IT services (such as software, storage, or computing power) that are delivered over the internet from remote data centres instead of on-site infrastructure.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.

3 Mangement response form

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should ensure when it refreshes its digital strategy there is a clear relationship between this and the clinical services and workforce strategies that are also in development. (**Paragraph 12**)	Agreed. The Digital Strategy will be shortly refreshed. The new clinical services plan launches 22 June 2026. Digital Foundations describes how delivering the CSP will be supported. DF was developed and prioritised with lead clinicians (Deputy MD, CCIO, CNIO). Prioritisation was further validated through workshops (over 40) and via a Resident Doctor survey. Digital plans will flex as the needs of the organisation change. The workforce strategy is being redeveloped in light of organisational restructure discussions; a refreshed document is expected in Q4 2026-27. Digital plans will flex as the needs of the	Feb 2027 Sept 2026 Feb 2027	Director of Digital Transformation

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		organisation change and become known. Digital literacy is core to a revised digital, clinical and workforce strategy. Following a recent audit, a Digital Skills Academy led by ECOD in HR is being established and is supported by the Director of Digital Transformation.	Feb 2027	
R2.1	The Health Board should build a clear understanding of where there are gaps in Board Members knowledge of the Health Board's digital arrangements. (**Paragraph 16**)	The survey responses collected by Audit Wales in compiling this audit will be used to inform a forward agenda of topic areas for Board Member education on digital. Board Members have requested a deep dive on Digital plans and there is a plan to bring a Cyber discussion to a Board Development session in Quarter 3, 26-27. Cyber phishing exercises continue to run on a programmed basis providing online bite size training to any individual that inadvertently clicks on phish exercise links. These results are tracked by the IG/cyber group chaired by the Director Digital & health Intelligence who is also	October 2026 Complete / Ongoing programme	Director of Digital & Health Intelligence Director of Digital & Health Intelligence

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		SIRO. Persistent offenders receive targeted communications and are offered further training.		
R2.2	The Health Board should design specific Board development workshops and training to fill these gaps. (**Paragraph 16**)	Digital deep dives are undertaken as Board agendas can support. In addition to the Digital session, AI Deep Dive is scheduled later in 2026 led by the Director of Digital & Health Intelligence with input from the IM&T IM and WG's Head of AI.	November 2026	Director of Digital & Health Intelligence

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R3	The Health Board should strengthen its cyber security assurance, addressing the specific weaknesses identified through recent external assessments. (**Paragraph 27**)	Targeted engagement via the Strategic Leadership Team will ensure Clinical Boards receive consistent updates on cyber risks, incidents, and mitigation actions, improving local awareness and accountability. A standardised approach to cyber risk management is being implemented, requiring Clinical Boards to identify, assess, and record cybe risks locally, with central oversight through AMaT to support organisational assurance. Governance arrangements are being enhanced through improved communication channels, clearer roles and responsibilities, and increased Clinical Board engagement in relevant committees. In addition, Information Asset Registers are being completed and centrally consolidated to improve visibility of systems, risks, and ownership, reducing reliance on informal knowledge. These actions will strengthen organisational oversight, ensure consistent risk management, and improve resilience to cyber threats The cyber team needs staff additionality to support the required activities, however CAVUHB remains severely financially	Revised to 30 March 2027	Director of Digital & Health Intelligence

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		constrained with other high criticality competing pressures. Additionality is therefore unlikely unless the D&HI service undergoes some reshaping to better align resource and skill sets, hence the delivery date has been changed.		
R4	The Health Board should quickly develop a clear AI strategy and ensure this is underpinned by clear governance and risk management arrangements. (**Paragraph 30**)	A governance process with the Medical Director as SRO was communicated to Clinical Boards for AVT AI in clinical use cases. This included guard rails for usage. Co-pilot guard rails have been produced and will be validated and circulated in Q3 There are established processes to manage the IG aspects of AI tools but not all AI usage. This is work in progress as part of Digital Strategy Governance arrangements established corporately including the Clinical Design Authority chaired by the Nurse Informatics Lead.	Completed 24 March 2026 December 2026 30 March 2027	Assistant Director of Programmes D&HI Director of Digital Transformation

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		There is no additional resource to target at this work and so it is being managed within and by existing resources. This means delivery is slower than we would like. Full embedment is targeted for Q4. An AI strategy will form part of the re-issue of the Digital Strategy and is covered under item R1.	February 2027	
R5.1	The Health Board should strengthen its approach to digital skills by developing a clear understanding of any gaps in the digital skills of its workforce; and **(Paragraph 32)**	As part of the Digital Skills Academy, CAVUHB has engaged with Cwmpas (funded by WG) to understand what support can be available. First meeting 10 July 2026 with ECOD. The Digital Skills Academy is also developing a briefer survey than the HEIW one to help establish a baseline. Meantime, we understand HEIW are also looking to revise the survey referenced in **paragraph 32**.	30 December 2026	Director of Digital Transformation as part of Digital Skills Academy

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5.2	The Health Board should strengthen its approach todigital skills by developing a funded, structured and organisation-wide approach to addressing thedigital skills gaps. (**Paragraph 33**)	CAVUHB remains severely financially constrained. Additionality is therefore unlikely. Following engagement with ECOD and Cwmpas, a plan will be developed that can be delivered within existing resources that explains how CAV will strengthen its approach to digital skills. Digital Foundations if funded will provide some support to resolving this issue as it comprises a number of new digital modules which staff will need to be trained upon and then use daily. The Digital Skills Academy plans to develop a Sharepoint site to direct staff towards for relevant training.	30 December 2026	Director of Digital Transformation as part of Digital Skills Academy

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6	The Health Board should develop a clear financial contingency plan for funding its digital transformation ambitions if additional Welsh Government funding is unavailable. (**Paragraph 40**)	If Digital Foundations is not funded CAVUHB will have to rely upon incremental improvements that can be delivered by its existing workforce. This will require use of the recurrent discretionary capital allocation earmarked for Digital and to utilize any potential in-year capital slippage that CAVUHB can bid for. Procurement preparatory work will be done up to the point of financial commitment to ensure best use of any additional funding. Discretionary capital funding has in 2026 been increased to £1m from £500k pa which gives D&HI the ability to plan for some improvement, however there is significant legacy to resolve in order to deliver real change. In tandem, procurement plans are being progressed in the event that additional capital slippage funding is made available again this year.	December 2026	Director of Digital Transformation Director of Digital Transformation

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Regional working opportunities are starting to be investigated by Directors of Digital which may also contribute to improvement and release some expenditure for reinvestment if efficiencies in regional working can be found.		
R7.1	The Health Board should ensure that it provides clearer assurance to Board on if its digital developments are positively impacting digital exclusion. (**Paragraph 37**)	CAVUHB remains severely financially constrained. Additionality is therefore unlikely and so this will need to be delivered within existing resources. The D&HI PMO will be tasked to consider how best to do these assessments as part of its programme management governance arrangements. Project process will include use of the Welsh Government Digital Inclusion Toolkit from July 2026/27 onwards. This will strengthen consideration of Digital inclusion to CaV Digital Implementations: Digital inclusion evaluation toolkit	Starting July 2026 This will be ongoing work	Assistant Director of Programmes D&HI

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		CAVUHB Director of Digital & Health Intelligence is a member of the WG Digital Inclusion Wales Alliance Oversight Group, having been invited to join this in June 26 to represent the health service.		
R7.2	The Health Board should ensure that its co-production approach to digital developments is consistently used. (**Paragraph 39**)	CAVUHB will continue to develop its' clinical design authority and workforce engagement with this (as appropriate). Co-production is achievable for local initiatives. There are several recent examples such as improving the EU workstation. Projects raised with D&HI trigger a 'brief stage' within the D&HI project methodology. This stage identified the SRO and operational leads behind the request, also capturing the 'benefits' of a digital change from the customer/operational perspective. Whilst the exact level of co-production varies with the nuance of the workload, this 'SRO' and 'service' remain intimately involved in the	Ongoing	Director of Digital Transformation Assistant Director of Programmes D&HI

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		design and prioritisation process of D&HI works. This includes the sign-off of initiative scoring and the regular collective prioritisation of Digital works by a DAB (Digital Advisory Board), which has a senior Clinical Board member present from every Clinical Board.		
R8	The Health Board should ensure that at least twice a year it reports progress on delivering the agreed benefits of its digital programme to the Digital & Infrastructure Committee. (**Paragraph 52**)	Agreed A delivered projects benefits register can be made available to the Infrastructure and Digital assurance committee on a bi-annual basis to identify the operational benefits (as identified by the operational SRO) of D&HI delivered projects and programmes.	Starting August 2026	Director of Digital & Health Intelligence

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

Report Title:	Procurement Compliance Report				Agenda Item No:	2.5
Meeting:	Audit & Assurance Committee		Public		Meeting Date:	1st September 2026
			Private	X		
Status	Assurance	X	Approval		Information/Noting	
Lead Executive Title:	Executive Director of Finance					
Report Author Title:	Deputy Director of Procurement Services and Executive Procurement Lead – C&V					

Main Report

Background and Current Situation:

It is widely recognised 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.

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

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (27)

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	£64,350.00	Retrospective POI	AWMGS	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.
APORT GLOBAL - SAMPLE MOVEMENT BETWEEN BIOBANK AND LN2 SHED	£13,719.00	One-off Requirement	AWMGS	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.
DYNEX DSX COMPREHENSIVE ANNUAL SERVICE CONTRACT	£5,250.00	12 months	Clinical Diagnostics and Therapeutics	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services advised the stakeholder that they were in breach of the Health Board's Standing Financial Instructions (SFIs) and confirmed that the requirement would be incorporated into the Procurement workplan to facilitate a compliant procurement process upon renewal.
REFINE, GRANT REF: 1220, STUDY REF: 9142 CARDIFF UNIVERSITY TRIAL MANAGEMENT	£124,281.33	01/10/25 until 30/06/27	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services has requested a full breakdown of expenditure relating to Cardiff University grant funding to enable assessment of the arrangements currently in place and to establish an appropriate governance approval for future activity where required.
SECURITY AT HOC	£56,866.00	April to August 2026	PCIC	No engagement with Procurement Services occurred prior to the requisition being raised.	This service has now ceased due to a lack of funding. However, the non-compliance issue has been escalated through the Clinical Board to ensure that lessons are learned and to help prevent a recurrence in the future.

REMOVAL OF ONE EXISTING AP200 FAN UNITS, REPLACE WITH A NEW CMVECO 200 0.37KW 1420RPM 240/1/50 IP55 INCLUDING AV MOUNTS	£7,575.00	One-off requirement	Clinical Diagnostics and Therapeutics	No engagement with Procurement Services occurred prior to the requisition being raised.	One-off requirement that is critical to the delivery and continuity of the service.
AROMA APP	£5,220.00	19th June - 18th December 2026	Capital, Estates and Facilities	No engagement with Procurement Services occurred prior to the requisition being raised.	The development of the app commenced without any involvement from Procurement Services and was only brought to the attention of Procurement Services after a supplier had been appointed and the app had been developed. To mitigate the immediate risk and improve compliance, Procurement Services negotiated a reduction in the contract term from 12 months to 6 months. During this period, discussions are being undertaken with end users to establish a longer-term compliant contractual arrangement and appropriate procurement route.
FNF LEVEL 3 MEMBERSHIP	£5,885.00	1st April 2026 - 31st March 2027	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services have engaged with the end user to determine whether there is any anticipated future spend with this supplier. If a continuing requirement exists, a compliant contract will need to be put in place. In addition, procurement training has been offered to the end user to strengthen awareness of procurement requirements and support future compliance.
SUNCHIP 2 OPEN SET 50_02_060	£7,214.45	One-off requirement	Surgery	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services advised the service of its obligations under the Standing Financial Instructions (SFIs) and is currently working with the supplier to establish a compliant contractual arrangement and prevent further breaches.
SUPPLY OF MATERIALS	£22,631.00	One-off requirement	Capital, Estates and Facilities	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.

TRAINING MODULE	£6,200.00	One-off requirement	Capital, Estates and Facilities	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.
LLAN HEALTHCARE SUBSTANCE MISUSE SERVICE	£15,860.00	12 months 26/27	PCIC	The award of the contract was delayed while requirements were being scoped and the necessary approvals and sign-off processes were completed.	An SLA has been added to the workplan to ensure future renewals are identified at an earlier stage, providing sufficient time for review and renewal arrangements to be completed in a compliant manner.
LIFT SHARE TO WORK PLATFORM	£5,125.00	01/03/2026 - 28/02/2027	Capital, Estates and Facilities	No engagement with Procurement Services occurred prior to the requisition being raised.	The previous contract was entered into without any involvement from Procurement Services and included an automatic renewal clause, resulting in non-compliant expenditure. Procurement Services has since opted out of the auto-renewal provision and will commence work to establish a new compliant contractual arrangement.
PAYMENT OF MENCAP INVOICES	£7,310.00	One-off requirement	Children and Women	No engagement with Procurement Services occurred prior to the requisition being raised.	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.

PAYMENT OF INVOICE FOR THE PROVISION OF ALL WALES NATIONAL TOOLKITS FOR RESPIRATORY, LIVER, TRACHEOSTOMY, WINTER PLAN, HEADACHE, AND LONG COVID 2025/26 - CVUHB SHARE ONLY	£128,571.00	1st April 2025 - 31st March 2026	Executives	The All Wales contract expired in 2025; however, the provider continued to deliver the service through the ICST app as no decision had been taken to terminate the service. Procurement Services has been awaiting direction from the SRO on whether the requirement should be re-procured, together with a specification to support any future procurement exercise. CEMT agreed to fund the 2025/26 invoices, and this payment relates to the CVUHB share of those costs.	The SRO has been advised that a decision is required on the future of this service. Either instruction must be provided to the supplier to terminate the provision of the app, or Procurement Services must be instructed to undertake a procurement exercise, supported by an agreed specification and associated requirements.
SYNNOVIS PAYMENT	£22,629.87	Retrospective payment	Clinical Diagnostics and Therapeutics	The award of the new contract was delayed due to a dispute with Synnovis regarding the framework fee, which needed to be resolved before the contract could be finalised.	The delay in awarding the new contract is due to HTE's ongoing discussions with Synnovis regarding the framework fee, with HTE seeking to avoid passing this cost on to the Health Board.
RESEARCH CONSULTANCY FOR PELICAT STUDY	£11,750.00	One-off requirement	Surgery	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services discussed with the end users the importance of engaging Procurement Services at the earliest opportunity for all procurements above the relevant threshold, to ensure contractual and procurement compliance is completed before any work commences.
MRC HOLLAND MLH1 AND MSH2 (HNPCC)	£5,800.00	One-off requirement	AWMGS	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services discussed the matter with the department and highlighted that the supplier is currently not contracted. The department has been asked to confirm whether there is an ongoing requirement, in which case a compliant contractual arrangement will need to be established.

GUTTMANN SPINAL CONFERENCE 11TH AND 12TH JUNE 2026	£22,741.66	One-off requirement	Specialist	No engagement with Procurement Services occurred prior to the requisition being raised.	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.
STEMCELL TECH UK – ROBOSEP HU WB AND BM CD138 POS SEL KIT !!	£11,500.00	One-off requirement	AWMGS	No engagement with Procurement Services occurred prior to the requisition being raised.	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.
IPCRESS STUDY	£5,256.00	One-off requirement	Clinical Diagnostics and Therapeutics	No engagement with Procurement Services occurred prior to the requisition being raised.	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.
DOCUMENT STORAGE	£5,775.68	March 2025 - June 2026	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	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.
STORAGE OF STEM CELLS	£5,280.00	13th January 2026 to 5th May 2026	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services made the requisitioner aware of the relevant procurement thresholds and requirements. Further information has been requested regarding any ongoing or future use of the supplier to determine whether a compliant contractual arrangement needs to be put in place.

SECURE TRANSPORT FOR MENTAL HEALTH	£48,906.00	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.
SERVICE AND CALIBRATION OF CENTRIFUGES IN LAB	£5,530.00	One-off requirement	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	Procurement Services is currently exploring the establishment of a compliant contractual arrangement to cover any ongoing requirement and future invoices associated with this supplier.
RADIATION SAFETY REVIEW	£7,160.00	One-off requirement	Executives	No engagement with Procurement Services occurred prior to the requisition being raised.	The work commenced in 2024 without any involvement from Procurement Services. Procurement Services has since engaged with the Research & Development (R&D) team and advised that, should the requirement continue, a compliant contractual arrangement will need to be established going forward.
HEALTH ROTA MEMBERSHIP LICENCE	£5,522.50	One-off requirement	Specialist	No engagement with Procurement Services occurred prior to the requisition being raised.	This represents a second-year purchase with a value exceeding £5,000. A quotation was obtained via the G-Cloud 14 Framework; however, the item description does not align with the services available under the framework, which is intended for Cloud Software and associated cloud support services. As a result, the procurement route used is considered non-compliant.

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (3)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action /Status
BIFFA MULTI LOT WASTE COLLECTIONS	£353,500.00	31/03/27	One-off requirement	Capital, Estates and Facilities	When the contract was originally awarded, there was the inclusion of a scheme for a social enterprise to collect carboard waste free of charge and then turn this into animal bedding. This reduced the value of the contract by £373,616.87.	Procurement Services and the Waste Department are currently collaborating on a multi-lot open tender to secure replacement arrangements for this contract, alongside a related waste services agreement, to

					However, since the contract was awarded, this service was stopped as the supplier could not keep up with demand and Biffa started collecting this waste stream, in turn causing a breach to contract value.	ensure ongoing service provision through a compliant procurement process.
DELIVERY AND COLLECTION COOLBREEZE 50B SPLIT AIR CONDITIONER DAMAGE WAIVER @7.50%	£5,138.00	18/08/26	3 months	Capital, Estates and Facilities	Emergency order, breaching the contract value	The expenditure arose from an emergency requirement and resulted in spend exceeding the approved contract value. Due to increased demand for the service, Procurement Services is now establishing a new contractual arrangement to ensure adequate capacity and the continued delivery.
SPECIALIST EQUIPMENT FOR THE PICCOS RESEARCH TRIAL	£7,200.00	2027	One-off requirement	Executives	SQA in place until 2027 but value has breached	A new contractual arrangement will be established to take account of the additional spend and ensure ongoing compliance.

Other Non-Compliant Activity (5)

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

- Emergency activity
- Unforeseen/Unplanned circumstances

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status
4TH-8TH MAY LABOUR FOR WELSH WATER INFRINGEMENTS	£5,378.39	One-off Requirement	Capital Planning Estates and Facilities	Unforeseen / Unplanned Circumstances	Agreed as one-off unexpected unplanned spend
CONCORDIA MEMBERSHIP	£14,892.00	12 months	Executives	Emergency Activity	Added to workplan to pick up on renewal with more time to get a compliant process in place to support the spend
URGENT DUCTED FUME CUPBOARDS FOR WEQAS	£19,155.00	1 month	Children and Women	Urgently required not enough time to put procurement governance in place	Insufficient time to complete compliance due to urgent requirements and delays through repair issues
AC COOLING UNITS	£26,770.60	One-off Requirement	Capital Planning Estates and Facilities	Emergency Activity	Emergency requirement during heatwave to cool down Theatres and other areas across

					HB to mitigate clinical service risk.
SUPPLY & INSTALLATION OF 7X DUALCOM TRANSMITTERS FOR THE ACCOMMODATION BLOCKS AT THE UNIVERSITY HOSPITAL OF WALES.	£13,592.13	One-off Requirement	Capital Planning Estates and Facilities	Emergency Activity	One of the emergency works, Procurement has made end users aware that they need to allow time for contract to be established in the future.

Exemptions (7) (Permitted within SFI's)

Title	Value at Risk	Length at Risk/Breach	Clinical Board	Reason	Action /Status
PAYMENT IN ADVANCE OF DUTY AND TAX REF AWB 528908740255	£6,570.95	One-off Requirement	AWMGS	Exemption	This payment relates to an unavoidable statutory payment.
LEGAL SERVICES ACROSS VARIOUS LOCATIONS FOR THIS PERIOD	£110,657.40	One off requirement	Executives	Exemption	This expenditure is exempt under Legal Services.
RENT FOR UNITS 1&6 WEQAS	£25,611.25	24/06/2026-28/09/26	Clinical Diagnostics and Therapeutics	Exemption	Not applicable - Exempt rent.
CCHA SERVICE CHARGE AND INSURANCE 26/27	£109,599.00	12 months 26/27	Capital Planning Estates and Facilities	Exemption	Not applicable - Exempt service charges.
ENETS CENTRE OF EXCELLENCE	£6,150.00	5 Years	Specialist	Exemption	Exempt - Audit Services.
ELIPSE TRIAL COLLABORATION COSTS IMPERIAL	£1,645,497.31	01/02/2024 – 31/01/2030	Executives	Exemption	The **ELIPSE trial** (Evaluation of Lymphadenectomy In High Risk Prostate Cancer Surgery) is a major UK randomized controlled clinical trial. Led by Cardiff and Vale University Health Board and Imperial College London in collaboration with the University of Aberdeen, it investigates whether removing pelvic lymph nodes during high-risk prostate cancer surgery improves patient outcomes.
PAYMENT OF INVOICE FROM PAUL POPHAM FUND FOR ACCOMMODATION FOR BRITISH TRANSPLANT GAMES 2026	£7,212.76	August 2026	Specialist	Exemption	Pass through funding from Welsh Government.

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 organisational requirements.

Report on Single Tender/Quotations Actions

Retrospective – (Nil Return)

Prospective (within the permitted guidelines)

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

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
Clinical, Diagnostics and Therapies	Qiagen	Purchase of AmniSure Training Panel	£5,080.65	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

The summary below details all Clinical Boards that have been reported 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	5	0
Capital Planning, Estates and Facilities	17	7	20	29	10	1
Clinical, Diagnostics and Therapies	27	4	29	18	7	1
Executives	35	20	11	7	10	2
Medicine	3	0	9	0	0	0
Mental Health	10	0	4	4	1	0
PCIC	11	0	6	6	1	0
Specialist	11	2	10	2	2	2
Surgery and Dental	8	1	5	0	2	0
TOTALS	**147**	**34**	**117**	**70**	**42**	**7**

The Health Board recorded 11 fewer instances of non-compliant activity during this reporting period compared with the same period in the preceding 12 months, demonstrating an overall improvement in compliance.

STA/SQA's by Department

	2024/25 (FY)		2025/26 (FY)		2026/27 (YTD)	
Clinical Board	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached
AWMGS	6	1	1	0	0	0
Children and Women	2	0	2	0	0	0

Capital Planning, Estates and Facilities	7	0	2	0	0	0
Clinical, Diagnostics and Therapies inc. Weqas	34	0	13	0	1	0
Executives	22	2	2	0	0	0
Medicine	3	0	1	0	0	0
Mental Health	3	0	0	0	0	0
PCIC	4	0	0	0	0	0
Specialist Services	5	2	0	0	0	0
Surgery Services and Dental	9	0	1	0	0	0
Grand Total	**95**	**5**	**22**	**0**	**1**	**0**

Summary of the Key Issues progress

There has been a significant decrease in the number of SQA/STA requests during this reporting period, with only one SQA 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.

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

N/A

Recommendations:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

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

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*		

Impact Assessment

Please place an “x” in the below boxes where relevant
Risk: Yes
As outlines above.
Safety: No
Financial: Yes
As outlined above.
Workforce: No
Legal: Yes
As outlined above.
Reputational: Yes
As outlined above.
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

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

Report Title:	Post Payment End of year Report 2025-2026					Agenda Item No:	2.6
Meeting:	Audit & Assurance Committee		Public	✓		Meeting Date:	01.09.26
			Private				
Status	Assurance	✓	Approval			Information/Noting	
Lead Executive Title:	Catherine Phillips, Executive Director of Finance						
Report Author Title:	NHS Wales Shared Services Partnership: Amanda Legge, All Wales Post Payment Verification Manager						

Main Report

Background and Current Situation:

The Audit and Risk Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. The following key points should be noted:

General Medical Services (GMS): We progressed well this year with our GMS routine visits and all are either closed or in progress by the end of this financial year.

Beginning 2026/2027 we will be concentrating the first quarter on GMS visits only and incorporating both revisits and the practice routine visit. This is part of our ongoing recovery plan. Some vaccination claims are now being claimed on the Welsh Immunisation System (WIS) and due to PPV highlighting the issues we found whilst conducting our verification checks, new internal process changes have been implemented to stop the duplicate vaccination payments prior to payment and not post payment, which is beneficial to everyone.

General Ophthalmic Services (GOS): The visit plans for GOS 2025-2026 progressed better than the last few years, based on the team having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We have had to still carry out elements of physical visits too, as not all contractors are electronic.

In 2025/2026, we verified claims for an additional 2 services, which were the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5). These checks have been going well with learning shared with our contractors and our teams.

General Pharmacy Services (GPS): In 2025-2026, the PPV team undertook checks on the Collaborative Working Scheme along with the Quality and Safety Scheme which we conduct remotely by verifying the data we hold against the evidence that we request from the contractors. This again has been positive for all HB, PPV team and contractor learning.

Additional Service: The quarterly dispensing data checks were completed, and we introduced a robust service moving forward into the new financial year, which resulted in financial recoveries. The results for the dispensing practices across Wales are noted on the report although there are no dispensing practices currently in Cardiff and the Vale University Health Board.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and Community Pharmacies in respect of Waste Management alongside the clinical waste self-assessments required to be completed by our contractors every three years. We will incorporate our WGOS contractors into our clinical waste process in the next financial year.
Meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.
The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services. The team also arrange quarterly National GMS, GOS Working Group meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.
PPV training requirements continue to be delivered to Health Boards and contractors, whenever needed and we also facilitate one-on-one training requirements when requested, particularly for new practice staff within the Primary Care setting.
We currently have our data analysts looking at producing some PPV dashboards with information for submission to future committee meetings.

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

CVUHB End of year PPV Report 2025-2026

Recommendations:

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

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

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

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

Risk: Yes

The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving throughout the claiming process.

Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

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

Audit Report - 1st April 2025 to 31st March 2026 = Cardiff & Vale University Health Board

General Medical Services (GMS)	C&VUHB							ALL WALES				
	Visit Type	HB Annual Visits Due	No. In progress/completed	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress/completed	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
GMS 2024 - 2025	Combined		37				£36,578.79			197		**£251,104.95**
GMS 2025-2026	Routine	12	12	184	£6,157.57	£5,782.03	£11,939.60	103	102	£90,453.80	£78,478.28	£168,932.08
	Revisit	26	10	267	£8,656.28	£2,533.46	£11,189.74	148	54	£48,503.83	£6,589.04	£55,092.87
	TOTAL	**38**	**22**	**451**	**£14,813.85**	**£8,315.49**	**£23,129.34**	**251**	**156**	**£138,957.63**	**£85,067.32**	**£224,024.95**

General Ophthalmic Services (GOS)	C&VUHB					ALL WALES		
	Visit Type	Annual Visits Planned	No. In progress/Completed	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress/completed	All Wales Value of Recoveries
GOS 2024-2025	Combined		13		**£2,287.24**	100		**£16,316.67**
GOS 2025-2026	Routine	24	20	54	£2,266.08	151	129	£14,541.93
	Revisit	2	2	19	£879.44	9	9	£3,844.04
	TOTAL	**26**	**22**	**73**	**£3,145.52**	**160**	**138**	**£18,385.97**

General Pharmacy Services (GPS)	C&VUHB					ALL WALES			
	Visit Type	Annual Visits Planned	No. In progress/completed	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress/completed	No. Recoveries	All Wales Value of Recoveries
GPS 2024 - 2025	Combined	34	34		£10,468.80		238		£48,153.27
GPS 2025 - 2026	Routine	30	28	6	£5,024.36	232	228	45	£42,777.84
	TOTAL	**30**							

New Recovery process					
DISPENSING 2025-2026	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy	Quarter 4 2024/25 (Jan to Mar 2025)	0	**£0.00**	64	**£24,444.29**

Report Title:	Car Parking Procurement – Lessons Learned				Agenda Item No:	2.7
Meeting:	Audit Committee	Public	X		Meeting Date:	01.09.26
		Private				
Status	Assurance		Approval		Information/Noting	X
Lead Executive Title:	Executive Director of Finance					
Report Author Title:	Deputy Director of Procurement Services and Executive Procurement Lead – C&V					

Main Report

Background and Current Situation:

Contract Overview

Cardiff and Vale University Health Board (Health Board) supported by NHS Wales Shared Services Partnership (NWSSP) undertook a competitive procurement exercise for the provision of Car Parking Management Services across its principal hospital sites, including the University Hospital of Wales, University Hospital Llandough, Cardiff Royal Infirmary, St David's Hospital and Barry Hospital. The requirement sought a comprehensive parking management and enforcement solution to improve patient and visitor access, reduce misuse of parking facilities and support operational efficiency across the estate. The proposed contract was for an initial five-year term with options to extend for up to a further two years and was intended to operate at no direct cost to the Health Board, with income generated through parking enforcement activity.

The procurement was undertaken under the Procurement Act 2023 using an above-threshold competitive tender process with a 60% quality and 40% commercial evaluation methodology. Five bids were received, with National Parking Control Group Ltd achieving the highest overall evaluation score of 84% and being identified as the preferred bidder. The proposed operating model included a 25% share of enforcement income payable to the Health Board, with estimated annual income of approximately £300,000 to support parking infrastructure improvements, sustainability initiatives and discretionary Parking Charge Notice (PCN) cancellation arrangements.

Procurement Challenge and Outcome

During the standstill period, the incumbent supplier, ParkingEye Ltd, issued legal proceedings challenging the procurement outcome. The challenge raised concerns relating to the procurement process and the subsequent proceedings triggered the automatic suspension provisions under Section 101 of the Procurement Act 2023, preventing contract award.

In May 2026, the High Court refused the Health Board's application to lift the automatic suspension. The Court concluded that, under the new remedies regime established by the Procurement Act 2023, significant weight should be given to the public interest in ensuring that contract awards are demonstrably lawful before contracts are entered into. The Court found that the claimed operational benefits of the new contract did not outweigh the public interest in maintaining the suspension pending determination of the substantive procurement challenge.

Following consideration of the litigation risks, ongoing delays, resource implications, and uncertainty surrounding the final outcome of the legal proceedings, the decision was subsequently taken to abandon the procurement exercise. No contract was awarded and existing arrangements remained in place. This avoided further legal costs and procurement risk but resulted in the anticipated service improvements and revenue-sharing model not being implemented.

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

Lessons Learned

The challenge represents the first procurement award decision involving the Health Board to be subject to legal proceedings under the Procurement Act 2023. Whilst the substantive procurement challenge was never determined by the Court, the outcome of the suspension lifting application provided one of the earliest judicial interpretations of the Procurement Act 2023 remedies regime. The judgment highlighted a significant shift from the previous regulatory framework, confirming that the courts are likely to place greater weight on the public interest in ensuring the lawful award of contracts before permitting contract award to proceed. As a result, contracting authorities should anticipate an increased likelihood of contract award delays where challenges are brought and should factor this into procurement planning, governance and risk management arrangements.

In collaboration with colleagues from NWSSP Procurement Services, the Health Board has undertaken a review of the procurement process, the subsequent legal challenge, and the lessons arising from the Court's decision. The review has identified a number of key learning points and improvement opportunities to strengthen future procurement activity, enhance organisational preparedness for procurement challenges, and ensure continued compliance with the Procurement Act 2023. The lessons learned have been grouped into the categories set out below.

1. **Procurement Planning and Strategy**
    a. **Early legal challenge risk assessment is essential**

The incumbent supplier was well established, had detailed operational knowledge and a clear commercial incentive to challenge the award. Future procurement strategies for high-profile/high value contracts should include a formal assessment of challenge risk and associated mitigation measures.

    b. **Build challenge scenarios into project planning**

The procurement timetable assumed successful contract award and mobilisation. The case demonstrates that under the Procurement Act 2023, a challenge may stop implementation for many months. Future complex and high-profile projects should include contingency plans for prolonged suspension periods where possible.

    c. **Consider whether benefits justify litigation risk**

The anticipated benefits of the new contract did not persuade the Court that implementation could not wait until the dispute was resolved. In future the Health Board should critically assess whether expected benefits are sufficiently material and urgent to support defending a challenge through litigation.

2. **Procurement Documentation**

    a. **Strengthen quality assurance before publication**

A number of the issues raised by the challenging supplier related to procurement notices, identification of the contracting authority, contract valuation and procurement classification. While these matters were not determined by the Court as part of the suspension application, the

challenge demonstrated the level of scrutiny that procurement documentation may be subject to during legal proceedings. Future procurements, particularly those involving revenue-sharing arrangements or non-standard commercial models, should be subject to enhanced legal and procurement assurance prior to publication to ensure that contract values, procurement classifications and contracting authority details are accurate, robust and clearly documented.

3. **Evaluation and Audit Trail**
    a. **Evaluation Records and Moderation**

The challenge highlighted the importance of comprehensive evaluation records and audit trails. Future procurements should ensure that individual evaluator assessments, moderation discussions, scoring rationales and final consensus decisions are clearly documented and retained. Procurement records should be maintained on the basis that they may be subject to legal disclosure and should provide a clear, auditable record of how evaluation outcomes were reached and procurement compliance was achieved.

4. **Procurement Act 2023 Lessons**
    a. **Automatic suspensions now present a significantly greater risk**

This is arguably the most important lesson from the case. The Court found that the Procurement Act 2023 establishes a different and more procurement-specific test than the previous regime, placing substantial weight on the public interest in ensuring lawful contract award before contract signature. Under previous procurement legislation, authorities were often successful in lifting a suspension where damages were considered an adequate remedy. The Court confirmed that adequacy of damages is now only one factor within a broader balancing exercise.

    b. **Authorities should expect longer delays where challenges arise**

The judgment indicates that procurement disputes may remain unresolved until trial unless there is a compelling public interest requiring implementation. This creates additional delivery and resourcing risks.

    c. **Public interest arguments require strong evidence**

The Court was not persuaded that the authority's claimed service improvements justified lifting the suspension. Future applications would require stronger evidence demonstrating urgent public benefit or service continuity risks.

5. **Contract Management**
    a. **Existing contracts should be fully utilised before pursuing alternative solutions**

The judgment noted that some benefits described as advantages of the new contract already existed within the incumbent arrangements but had not been fully implemented or enforced.

    b. **Strong contract management supports future procurement decisions**

Where service shortcomings are used to justify change, the Health Board should ensure there is evidence of performance management and attempts to drive improvement under the existing contract.

6. **Governance**
    a. **Governance, Escalation and Management of Procurement Challenges**

Issues arising during the standstill period should, in the first instance, be managed by the lead Procurement Team, supported by internal stakeholders and proportionate legal advice where required. Procurement staff are typically best placed to respond to clarification requests, concerns and challenges due to their detailed knowledge of the procurement process and evaluation methodology.

The challenge highlighted the importance of having clear governance, escalation and decision-making arrangements for procurement-related disputes. Future challenges should be assessed on a proportionate basis, with escalation to Legal & Risk Services and external advisers informed by the complexity, materiality and litigation risk presented. Early engagement and open dialogue with aggrieved bidders should be encouraged to resolve issues wherever possible and avoid unnecessary escalation, delay and cost. Consideration should also be given to the most appropriate source of specialist support, balancing risk, expertise and value for money when determining whether external legal advisers should be engaged.

Future Opportunities and Improvements

The Health Board and NWSSP Procurement Services have jointly reviewed the procurement exercise, legal challenge and subsequent abandonment of the Car Parking Management Services procurement to identify opportunities for improvement and strengthen future procurement activities. The lessons arising from this review will be incorporated into relevant procurement procedures, guidance, governance arrangements and assurance processes to support continuous improvement and ensure organisational learning is embedded across both organisations.

Particular focus will be placed on strengthening procurement planning, challenge risk assessment, documentation assurance, evaluation audit trails, governance and escalation arrangements, and awareness of the practical implications of the Procurement Act 2023. Consideration will also be given to reviewing existing training programmes and developing additional guidance for procurement and operational staff involved in the delivery of complex, high-profile or strategically significant procurements.

The Health Board and NWSSP Procurement Services will continue to work collaboratively to ensure that future procurements are supported by robust governance, proportionate legal and procurement assurance where required, clear decision-making processes and effective risk management arrangements. This will help improve organisational resilience, strengthen compliance, reduce the likelihood of future challenges and enhance the ability of both organisations to respond effectively should procurement disputes arise.

Whilst the procurement did not ultimately result in contract award, the experience has provided valuable insight into the operation of the Procurement Act 2023 and the evolving judicial approach to procurement challenges. The learning derived from this case will be used to inform future procurement practice and support the delivery of fair, transparent and legally robust procurement outcomes across NHS Wales.

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

N/A

Recommendations:

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

Link to Strategic Objectives of Shaping our Future Wellbeing: Please place an "x" in the below boxes where relevant – *Click each item for further information.*			
1. Putting People First		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant									
Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*		

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes
As detailed above.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
Risks mitigated as detailed in the lessons learned above.
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

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

Report Title:	Risk Management					Agenda Item No:	2.8
Meeting:	Audit		Public	X		Meeting Date:	1 Sep 26
			Private				
Status	Assurance	X	Approval			Information/Noting	
Lead Executive Title:	Director of Corporate Governance						
Report Author Title:	Director of Corporate Governance						

Main Report
Background and Current Situation:

In the last year risk management in CVUHB has been interrogated by:

- 25/26 Structured Assessment by Audit Wales;
- Apr 26 Internal Audit report (Reasonable Assurance);
- Aug 26 Independent Assessment of CVUHB;
- throughout the escalation process.

The observations, actions or recommendations that have resulted are set out below.

	Source	**Observation/Action/Recommendation**
1	Audit Wales Structured Assessment Dec 25	While the Board receives the Corporate Risk Register (CRR) at each meeting, it is for information only and committee level oversight arrangements for corporate risks is still not clear.
2	Risk Management & Board Assurance Framework Internal Audit Apr 26	Risk Management Documentation - The Risk Management Policy, although recently updated for the introduction of AMaT contains some errors and inconsistencies, with links to supporting documentation that is out of date.
3	Risk Management & Board Assurance Framework Internal Audit Apr 26	Data Cleansing - The migration of risks onto the AMaT system is largely complete and some directorates have taken the opportunity to review the information recorded to ensure that it remains both current and relevant. However, other areas of the Health Board have not thus far taken this opportunity and with approximately 1500 risks on the system it is important that any out-of-date, irrelevant or duplicated information is removed where possible. We acknowledge that the Health Board are aware of this need and have set a deadline of the autumn of 2026 to achieve it.
4	Risk Management & Board Assurance Framework Internal Audit Apr 26	Clinical Board Executive Reviews - The evidence on the testing of the Executive Clinical Board Reviews was that whilst there were some references to risk, there appeared no consistency to the approach and very little tangible linking to formal risk registers. However, discussion with Risk Leads suggested that they are usually challenged on their key risks in these meetings. We are aware that the Health Board is currently reconsidering the structure and content of these reviews and having a formal and consistent slide on key risks for each Clinical Board would in our view be helpful.
5	Risk Management & Board Assurance Framework Internal Audit Apr 26	Corporate Risk Register - The Corporate Risk Register is reported to every meeting of the Board and contains all operational risks scoring 20 and above. However, the size of the register (186 risks as at March 2026) makes it unrealistic for Board members to scrutinise it in any meaningful way. The Corporate Risk Register is always scheduled at the end of the Board meeting and is provided for noting. The minutes

		of Board meetings only ever record that it was noted and there is never any record of a discussion of any of the risks contained within it.
6	Risk Management & Board Assurance Framework Internal Audit Apr 26	Sub-Committee Review of BAF - Whilst there is increased evidence of Board sub-committees reviewing issues that are recorded on the BAF, there remains an inconsistency of approach and a lack of an explicit link back to the strategic risks allocated to each Board committee.
7	1 Jul Escalation Board letter dated 14 Jul	The health board's risk register is unclear and some of the highest risks including quality, culture, access, productivity and performance, have remained unresolved for a prolonged period.
8	1 Jul Escalation Board letter dated 14 Jul	Concerns remain regarding organisational culture and the effectiveness of leadership and governance arrangements. In particular [2 of 5 bps]: • The need for a single and coherent view of organisational risk aligned to Board oversight and delivery arrangements. • The pace of delivery and delivery of mitigating actions against longstanding organisational risks
9	1 Jul Escalation Board letter dated 14 Jul	At the next meeting, the health board must demonstrate tangible evidence that planning activity has translated into measurable improvement and delivery, with more detail around the actions undertaken to improve the position across [1 of 4 bps]: • Risk identification and oversight…
10	Independent Assessment Aug 26	The current governance system is not serving the health board adequately in anticipating risks and issues and therefore providing an opportunity to develop mitigation plans.
11	Independent Assessment Aug 26	The health board has moved to a single digital risk management system AMaT (Audit Management and Audit Tracking) and published a new risk management policy in February 2026. This is a welcomed development and streamlines the previous disparate approach to recording risk. Whilst the leadership has identified the need to drastically improve risk management the IAs understand that there is not a current improvement plan in place. The IAs believe urgent and focussed attention is required here to strengthen this critical aspect of governance. A necessary next step is for CAVUHB to assure itself that its workforce understands and has the capability to effectively manage risk.
12	Independent Assessment Aug 26	Risk management is poorly understood by staff and underdeveloped across the health board.
13	Independent Assessment Aug 26	Urgently address the approach to risk management including the identification, classification, reporting of risk and importantly the required action needed to mitigate risk. In addition, the health board should discuss and agree its risk appetite, risk tolerance and how to prioritise and balance risk across the various domains.

The aim of this report is to:

1. Address the above points.
2. Introduce the revised Corporate Risk Register for endorsement to Board.

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

Introduction

This section seeks to set out:

1. A brief description of our Risk Management Framework as it stands today.
2. What we have done in the last 2 years to get us here – the plan and delivery.
3. What the current maturity of the framework is.
4. What the next steps will be.
5. How this speaks to the observations and actions set out in the above section.
6. How this will be tested.

Risk Management Framework

There's 3 layers:

1. Board Assurance Framework (BAF).

While it features in the risk management framework, the BAF is not primarily a risk register per se. It is the framework that we use to link the 4 strategic objectives through the 6 strategic portfolios and align them to CVUHB Committees. It identifies 6 strategic risk themes that apply to every objective and group strategic level themes that individually or collectively could prevent delivery of the strategy. This is a slow moving, reference tool that should be used as contextual document to the primary focus, which should be the delivery of the strategy.

2. Corporate Risk Register (CRR).

This is the document that seeks to expose the most significant operational risks within the organisation to a Board, Committee and Leadership level.

3. Organisational Risk Register (ORR).

This is the floor to Board, information-rich register of all risks in the organisation that can be used by and interrogated by every person in the organisation. It changes daily and currently captures ~1,470 risks within the AMAT risk module that has been co-designed by CVUHB and AMAT and is now being made available to NHS organisations across England and Wales.

What has been done?

The below chronology covers some of the key actions and discussions that have taken place over the last 2 years. It is set out in part to respond to the point in the IA report that there has been no improvement plan for risk and seeks to assure the Committee that there has been both a process and progress.

Date	Source	What
Apr 24	Internal Audit	Despite reasonable assurance, DCG drew the conclusion that CVUHB required a single, organisation-wide risk register.
Jun 24	Board Development	Full review of the BAF to align with the then recently approved strategy refresh and align with Committees
Sep 24	Board	Approval of the changes resulting from the above

Sep 24	AMAT	First meeting with AMAT to commence the co-design of an NHS Risk Module within their software
Jul 25	SLT	SLT briefed on proposal to switch to a single system – endorsed.
Aug 25	Board CRR Report	T&F Group established to introduce and train organisation on developing AMAT module
Oct 25	T&F Group	All 20+ risks migrated to AMAT
Nov 25	Board CRR Report	CRR to Board presented from AMaT for first time
Feb 26	SLT	Update on new risk management policy and progress on digital migration and oversight of risk
Feb 26	Audit Committee	Updated Risk Management Policy approved to reflect the significant changes of having a single system
Mar 26	Board	CRR report update on progress with digital migration and risk oversight arrangements
Apr 26	T&F Group	All risks migrated to AMAT – 70+ risk registers are no longer used in the organisation
May 26	Audit Committee	1. Update on Risks transferred to AMAT and action to report to Audit Committee on new CRR in Nov 26. 2. Internal Audit report on risk management (reasonable)
May 26	Board	1. Standing CRR report confirms transition to AMAT completed and provides analysis on data held 2. Reports that the T&F group will transition to an organisational risk management group (ORMG)
Jun 26	Quality Committee	All quality tagged risks scoring 20+ in ORR reported
Jul 26	People and Culture Committee	All people and reputational risks scoring 20+ in ORR reported
Jul 26	Finance and Performance Committee	All finance and performance tagged risks scoring 20+ in ORR reported to Committee
Jul 26	Management Executive Meeting	CRR Discussion
Aug 26	SLT	ORMG TORs approved
Aug 26	Management Executive Meeting	CRR Discussion

In addition to the above it should be noted:

1. Digital and Infrastructure Risks are a regular feature of the D&I Committee.
2. The CRR has been reported to every Board meeting.
3. Risk features in Clinical Board Reviews and has evolved with the use of AMAT. The format is that the CB will speak to their key risks in each meeting so that there is timely exposure of them with the Execs and a focused discussion on the mitigations in place or intended. In response, the CG team will provide analysis of their wider risk management so they can use it to manage their processes within their CB. An example from Jul's meetings is provided at Appendix 1.
4. Each CB has established its own internal system of risk management that has been used to validate the risks during the migration and then moderate the scoring, monitor actions etc.
5. The CG team have attended numerous risk training and moderation meetings with CBs/Dirs.

Where does this place us today?

There is documentation and correspondence relating to each of the lines in the table above which has focused on established meetings as a shorthand for the much wider work that has been undertaken across the organisation.

The Committee should be assured that this work amounts to the identification of the shortcomings of the Risk Management Framework as it was 3 years ago, and a resulting plan of work that has been identified and then delivered as stated, with the remaining steps set out below.

The transfer to the AMaT system has been overwhelmingly welcomed by CBs and Directorates and the burgeoning use of the system is encouraging and will continue to improve and be monitored through the ORMG and CB Reviews.

<u>Corporate Risk Register (CRR)</u>

A key finding of the Internal Audit report in Apr 26, which has manifested in slightly less specific ways in the engagement at Escalation Boards and the IA Report, is that the CRR was too large and that there was a resulting inconsistency in how the Board, Committees and Execs articulated the principle risks facing the organisation and the measures to respond to them.

The intent with the new AMaT system had been to use the scoring thresholds to derive the CRR; ie. the CRR would comprise of all risks scored at 20+. Initially this resulted in over 200 risks which has been reducing as moderation practices are harmonised through the ORMG and tested in the CB Reviews but is still too large. This work has resulted in 2 conclusions:

1. In an organisation of this size, there will never be a suitably manageable number of risks scoring 20+ that will allow a usable CRR to be discussed at Board and Committee level.

2. The risks are submitted and then managed within the CBs or Directorates. Therefore, to take the 20+ risks would mean to apply no filter that looks to establish whole organisation (corporate) themes and unifying risks.

As a result, a completely new CRR is presented today for **endorsement of the Committee to be submitted to Board**.

The CRR is a result of the following process:

- AI analysis of the whole ORR on a variety of themes/prompts that each asked for a top 12 based on criteria such as by causative themes, effect/impact themes, holistic view assessing language rather than scoring and several other filters;
- this produced 6 different top 12 proposals (so 72 individual or overlapping risks) that were then shaped into a shortlist of 20 by DCG;
- this shortlist was workshopped by Execs in July into 13 corporate risks that articulated the risk, cause and impact for each one;
- these 13 CRs were then processed back through the ORR using AI to derive the mitigating actions being taken;
- this resulting product was workshopped once again by Execs in August to refine risk ownership and then review the listed mitigations.

The result is the CRR at Appendix 2.

The CRR will continue to evolve as the reviews continue and it should be dynamic enough to change between presentations. Additionally, it will feed into the strategic portfolio and plan delivery work where the appropriate steps will be articulated that speak in part to the mitigation of the risks.

What still needs doing?

Board and Committees

It is intended that the CRR will be taken to every other Public Board – 3 times a year. Each cycle will go through a similar process of using AI to analyse the data rich ORR to test the risks within the CRR, and this will the be tested against the risks being highlighted by CBs and Directorates in their reviews and discussed in SLT and Execs prior to submission to Board.

The relevant risks within the CRR will also report to the Committees as a framing document that can act to introduce the greater detail of the organisational risks contained within the ORR.

The BAF will continue to feature in all Committees as a reference document for items that speak to the delivery of the strategy. The changes made to the Quality Committee and the introduction of AAA reporting will be rolled out to other Committees which will then frame agendas within the context of the strategy delivery.

Organisation Management

CB and Directorate Reviews will continue to 'pull' a discussion on the key risks and 'push' data that will ensure continuing cleansing of risk data and focus and learning of the workforce. The ORMG will augment this through the establishment of training, bespoke assistance and best practice.

Alignment

The ORR is already used to inform planning and decision making (the Capital Prioritisation work is a good example of this within Estates) and this will continue through the 27/28 planning process and the wider integrated improvement plan so that the risk discussions are linked through to these delivery and monitoring vehicles (with the evolving performance management framework and quality management system key too).

Risk must never become a task and finish in of itself and must inform these established or establishing golden threads.

Policy

The Risk Management Policy will update again and be presented to Audit Committee with any updates that result from this learning process.

How does this align with the actions set out in the first section from the 4 areas?

	Source	Observation/Action/Recommendation

1	Structured Assessment	CRR at Board and Committees
Response - CRR to Board Sep 26 for substantive discussion and then to Committees as directed.		
2	Internal Audit Apr 26	Risk Management Documentation
Response – completed		
3	Internal Audit Apr 26	Data Cleansing
Response – ongoing since Oct 25 and will continue to feature at ORMG and CB Reviews		
4	Internal Audit Apr 26	Clinical Board Executive Reviews
Response – push and pull approach as set out above derived from the ORR and ORMG to continue to deliver training and best practice		
5	Internal Audit Apr 26	Corporate Risk Register size
Response – new CRR proposed for endorsement at App 2		
6	Internal Audit Apr 26	Committee Review of BAF
Response – BAF appears in all Committees and will evolve with the changes to be rolled out re AAA reporting etc following Quality Committee example		
7	Escalation Board letter	Risk register is unclear and some have remained unresolved.
Response – ORR is a data-rich source of information that is managed in CBs/Dirs and through ORMG and CB Reviews. The new CRR is clear and purposeful. Some will remain unresolved.		
8	Escalation Board letter	Need a single/coherent view aligned to oversight and delivery with pace to mitigations.
Response – ORR is single point of truth and CRR is credible, corporate overview for use at leadership level. Alignment with delivery and management of mitigations will continue to evolve.		
9	Escalation Board letter	Must demonstrate planning has translated to measurable improvement and delivery of risk identification and oversight.
Response – this report serves as such evidence.		
10	Independent Assessment Aug 26	The current risk governance system is insufficient
Response – co-designed ORR is now being offered to other NHS organisations and the AI analysis is enabled by it. The CRR will evolve through challenge to provide leadership an effective tool.		
11	Independent Assessment Aug 26	There is not a current improvement plan for risk and no assurance that the workforce has the capability to effectively manage risk.
12	Independent Assessment Aug 26	Risk management is poorly understood by staff and underdeveloped across the health board.
Response – this report seeks to set out work undertaken and reported to Board, Committees and Leadership and the work of the CB Reviews and ORMG to grow capability with the new software		
13	Independent Assessment Aug 26	Urgently address the approach to risk management.
Response – the system and framework is established and work will continue iteratively on risk appetite and tolerance.		

How will this be tested?

In very simple terms, the Execs will appear at the Accountability and Escalation Meeting with WG on 15 Sep and be expected to be able to articulate the 13 Corporate Risks and speak to the

actions in train to address them, ideally within the context of the Integrated Improvement Plan and Strategic Portfolio delivery.

Board will have an opportunity to first test this in the subsequent Board meeting on 24 Sep 26.

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

1. Example of Risk Analysis provided to CB Review meetings.
2. Corporate Risk Register

Recommendations:

a) **Note** the work undertaken to date to develop and deliver and plan to improve risk management in CVUHB.
b) **Note** how the content of the repot speaks to the actions and observations set out in the background section.
c) **Endorse** the CRR for submission to Board in September.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

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

Five Waves of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention	X	Long Term	X	Integration	X	Collaboration		Involvement	X

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes		No	X	Corporate oversight not a specific service proposal

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

Risk: No
It's about risk, but it doesn't introduce risk
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
How we manage risks considers and can expose us to reputational considerations

Socio Economic: Yes/No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: https://www.gov.wales/socio-economic-duty-guidance*	
Equality & Health: No	
Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Children & Women

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	1	28	35	6	70

Review Dates

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	1	25	34	6	66
In Date	0	3	1	0	4

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	0	23	34	6	63
Tolerate	1	5	1	0	7

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	1	44	49	9	103
In Date	0	1	0	3	4

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	4	0	2	6
In Date	0	0	0	2	2

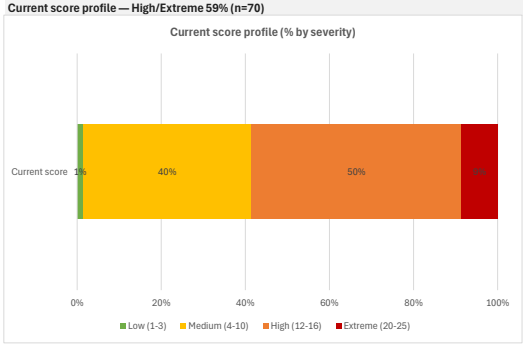
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	1	0	1	2
3 - 6 months	0	4	6	2	12
6 - 12 months	0	6	0	1	7
12+months	1	17	29	2	49

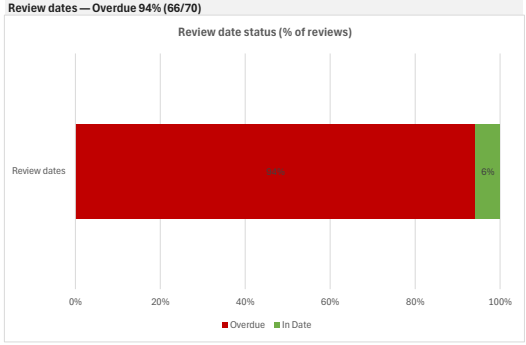
Children & Women — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

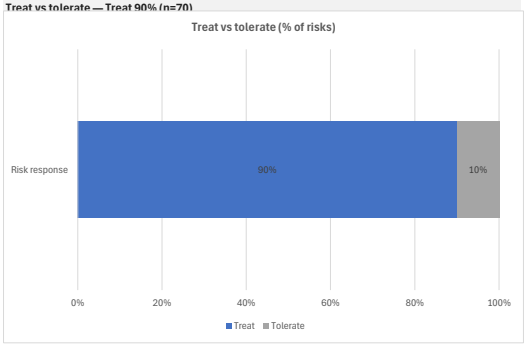
Current score profile — High/Extreme 59% (n=70)



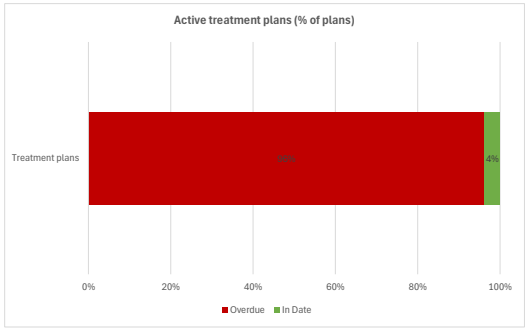
Review dates — Overdue 94% (66/70)



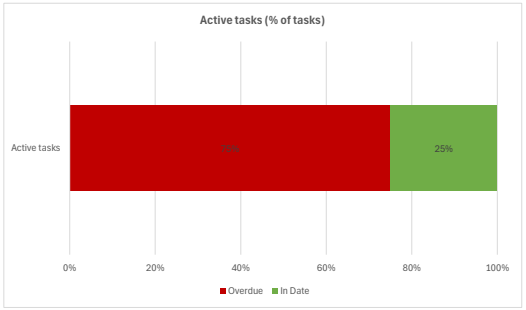
Treat vs tolerate — Treat 90% (n=70)



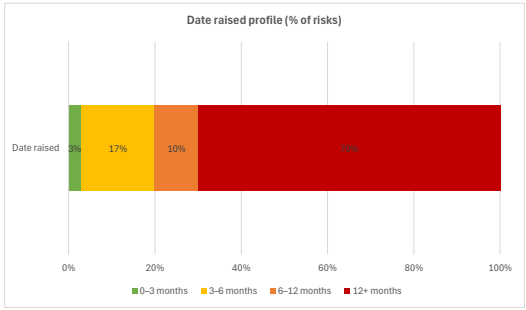
Treatment plans — Overdue 96% (103/107)



Active tasks — Overdue 75% (6/8)



Date raised — 12+ months 70% (49/70)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	1%	40%	50%	9%

Metric	Overdue	In Date
Review dat	94%	6%

Metric	Treat	Tolerate
Risk respo	90%	10%

Metric	Overdue	In Date
Treatment	96%	4%

Metric	Overdue	In Date
Active task	75%	25%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	3%	17%	10%	70%

Clinical Diagnostics & Therapeutics

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	2	61	97	12	172

Review

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	39	78	11	128
In Date	2	22	19	1	44

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	1	40	87	12	140
Tolerate	1	21	10	0	32

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	1	39	94	10	144
In Date	1	16	19	2	38

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	1	2	0	3
In Date	0	0	0	0	0

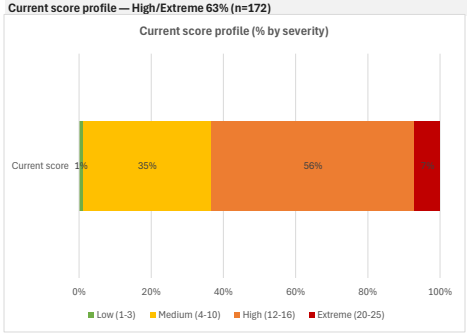
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	0	0	0	0
3 - 6 months	0	22	17	4	43
6 - 12 months	2	15	32	6	55
12+months	0	24	48	2	74

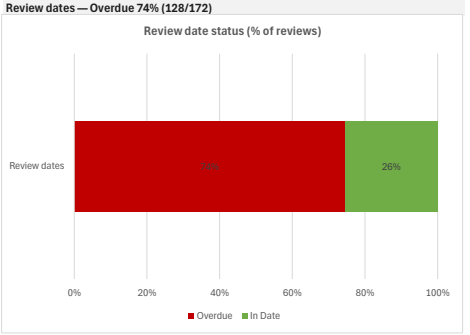
Clinical Diagnostics & Therapeutics — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

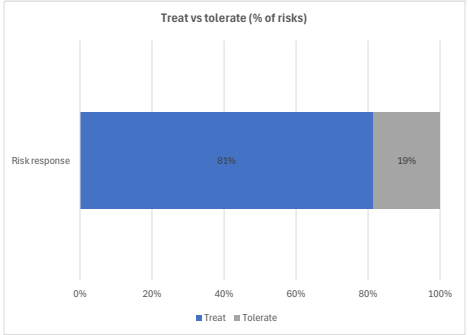
Current score profile — High/Extreme 63% (n=172)



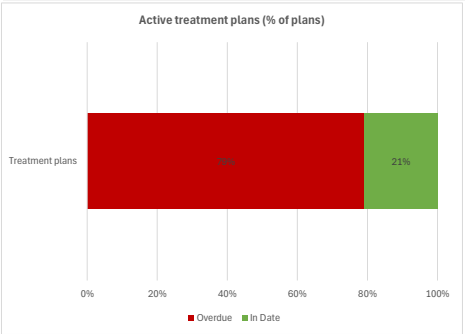
Review dates — Overdue 74% (128/172)



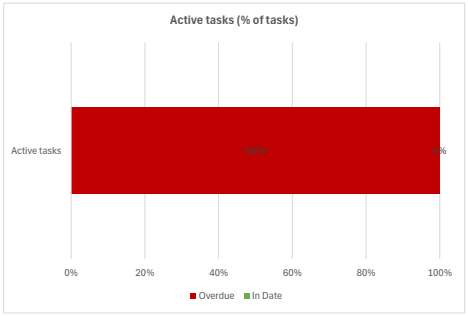
Treat vs tolerate — Treat 81% (n=172)



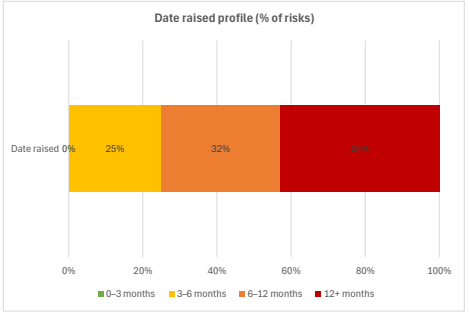
Treatment plans — Overdue 79% (144/182)



Active tasks — Overdue 100% (3/3)



Date raised — 12+ months 43% (74/172)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	1%	35%	56%	7%

Metric	Overdue	In Date
Review dat	74%	26%

Metric	Treat	Tolerate
Risk respo	81%	19%

Metric	Overdue	In Date
Treatment	79%	21%

Metric	Overdue	In Date
Active task	100%	0%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	0%	25%	32%	43%

Medicine

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	0	14	26	17	57

Review

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	13	26	17	56
In Date	0	1	0	0	1

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	0	13	23	13	49
Tolerate	0	1	3	4	8

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	29	46	30	105
In Date		1	1	1	3

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	0	0	0	0
In Date	0	0	0	0	0

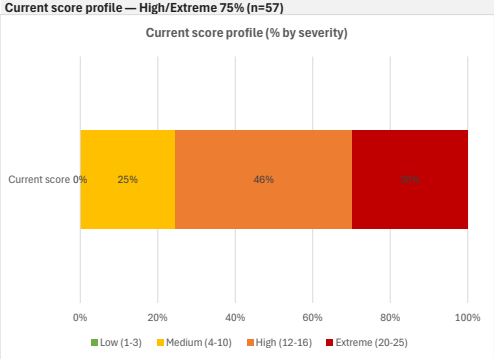
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	1	1	0	2
3 - 6 months	0	0	0	1	1
6 - 12 months	0	3	3	4	10
12+months	0	10	22	12	44

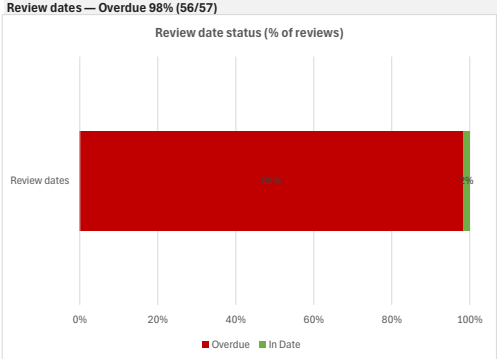
Medicine — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

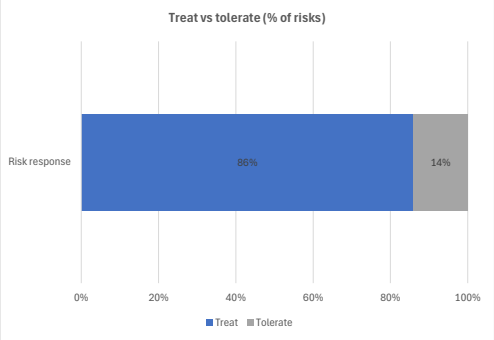
Current score profile — High/Extreme 75% (n=57)



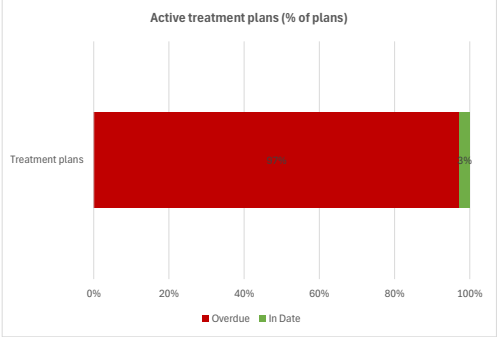
Review dates — Overdue 98% (56/57)



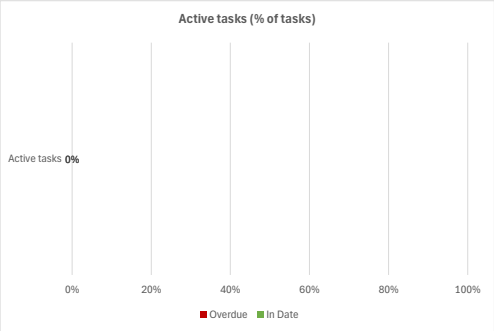
Treat vs tolerate — Treat 86% (n=57)



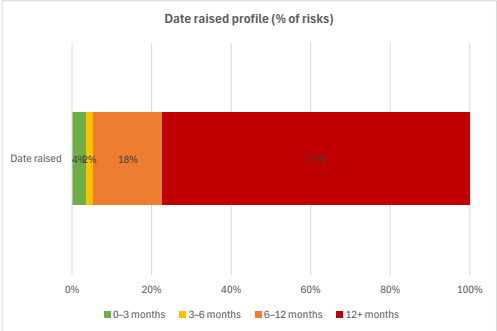
Treatment plans — Overdue 97% (105/108)



Active tasks — no active tasks recorded (n=0)



Date raised — 12+ months 77% (44/57)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	0%	25%	46%	30%

Metric	Overdue	In Date
Review dat	98%	2%

Metric	Treat	Tolerate
Risk respo	86%	14%

Metric	Overdue	In Date
Treatment	97%	3%

Metric	Overdue	In Date
Active task	0%	0%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	4%	2%	18%	77%

Mental Health

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	1	11	17	5	34

Review

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	8	13	5	26
In Date	1	3	4	0	8

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	1	6	17	5	29
Tolerate	0	5	0	0	5

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	10	11	6	27
In Date	1	2	11	2	16

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	0	0	0	0
In Date	0	0	0	0	0

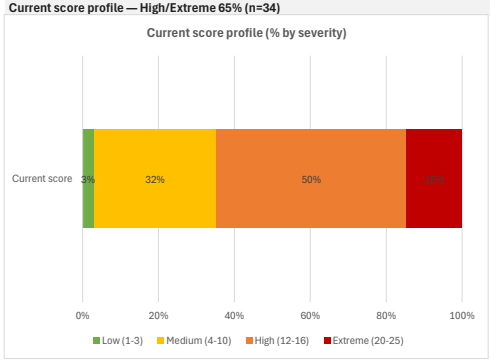
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	1	2	0	3
3 - 6 months	1	4	5	2	12
6 - 12 months	0	3	5	2	10
12+months	0	3	5	1	9

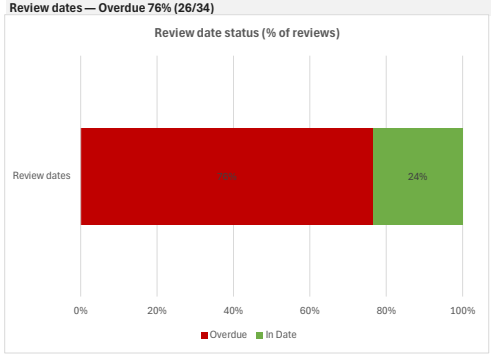
Mental Health — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

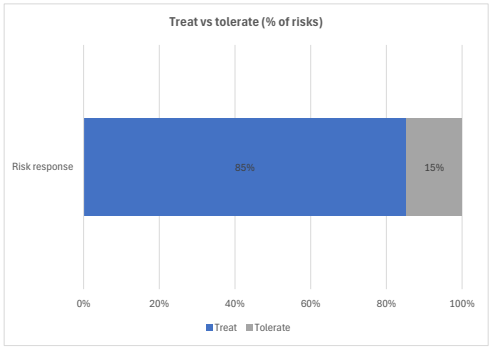
Current score profile — High/Extreme 65% (n=34)



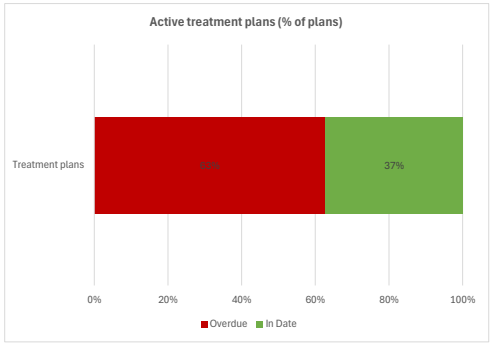
Review dates — Overdue 76% (26/34)



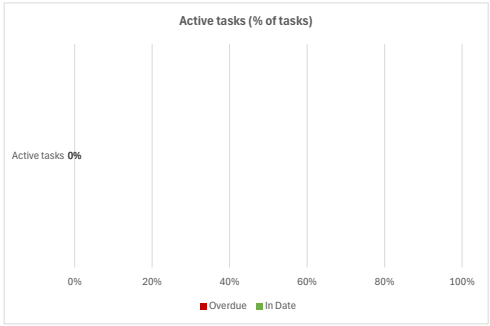
Treat vs tolerate — Treat 85% (n=34)



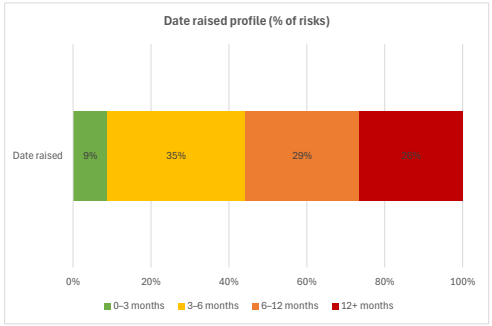
Treatment plans — Overdue 63% (27/43)



Active tasks — no active tasks recorded (n=0)



Date raised — 12+ months 26% (9/34)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	3%	32%	50%	15%

Metric	Overdue	In Date
Review dat	76%	24%

Metric	Treat	Tolerate
Risk respo	85%	15%

Metric	Overdue	In Date
Treatment	63%	37%

Metric	Overdue	In Date
Active task	0%	0%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	9%	35%	29%	26%

Primary, Community & Intermediate Care

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	1	26	43	11	81

Review

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	5	10	3	18
In Date	1	21	33	8	63

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	0	13	28	7	48
Tolerate	1	13	15	4	33

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	29	37	14	80
In Date	0	12	23	4	39

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	3	13	8	24
In Date	0	0	2	1	3

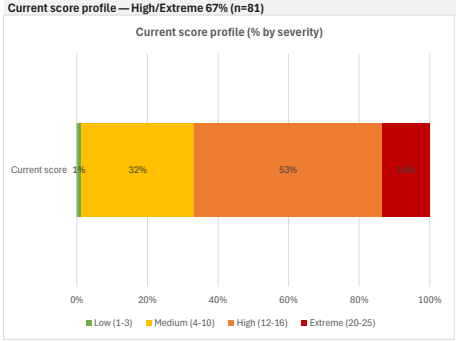
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	1	2	1	4
3 - 6 months	0	12	20	4	36
6 - 12 months	0	1	4	1	6
12+months	1	12	17	5	35

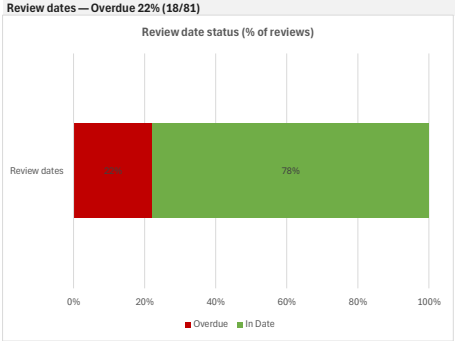
Primary, Community & Intermediate Care — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

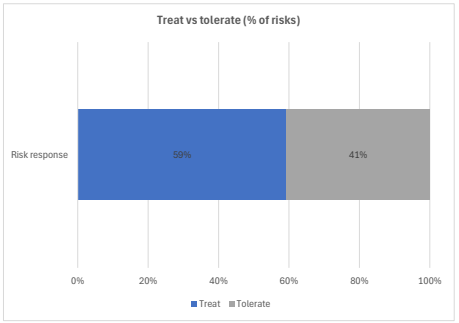
Current score profile — High/Extreme 67% (n=81)



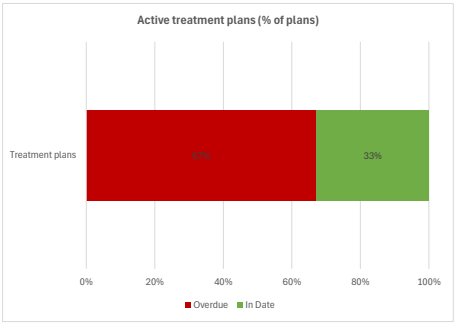
Review dates — Overdue 22% (18/81)



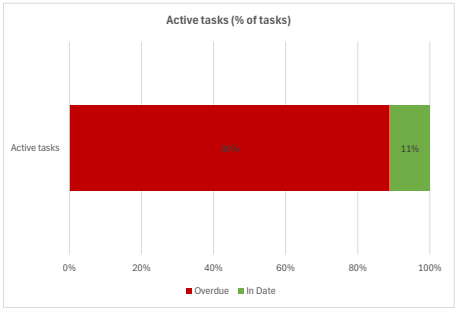
Treat vs tolerate — Treat 59% (n=81)



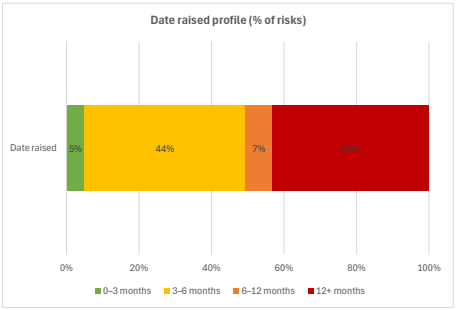
Treatment plans — Overdue 67% (80/119)



Active tasks — Overdue 89% (24/27)



Date raised — 12+ months 43% (35/81)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	1%	32%	53%	14%

Metric	Overdue	In Date
Review dat	22%	78%

Metric	Treat	Tolerate
Risk respo	59%	41%

Metric	Overdue	In Date
Treatment	67%	33%

Metric	Overdue	In Date
Active task	89%	11%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	5%	44%	7%	43%

Specialist Services

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	2	17	48	34	101

Review

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	2	9	37	28	76
In Date	0	8	11	6	25

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	2	15	44	32	93
Tolerate	0	2	4	2	8

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	1	11	41	35	88
In Date	0	8	24	14	46

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	0	2	0	2
In Date	0	0	0	1	1

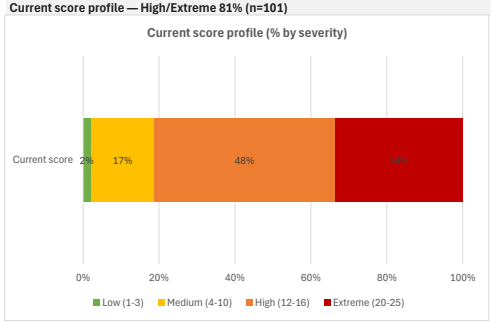
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	6	12	2	20
3 - 6 months	0	3	6	1	10
6 - 12 months	1	2	7	11	21
12+months	1	6	23	20	50

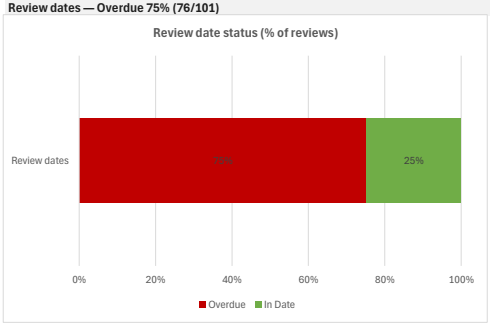
Specialist Services — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

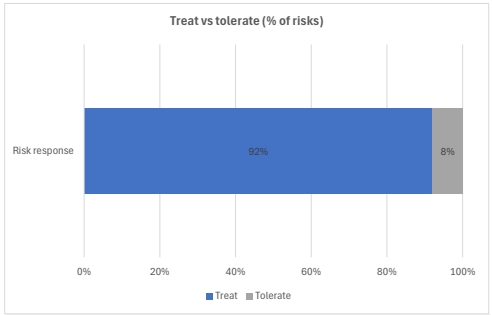
Current score profile — High/Extreme 81% (n=101)



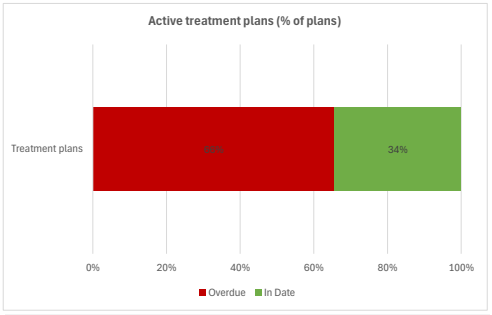
Review dates — Overdue 75% (76/101)



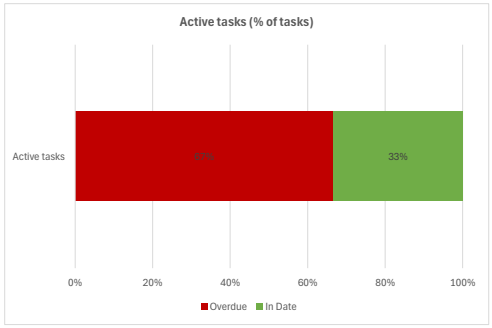
Treat vs tolerate — Treat 92% (n=101)



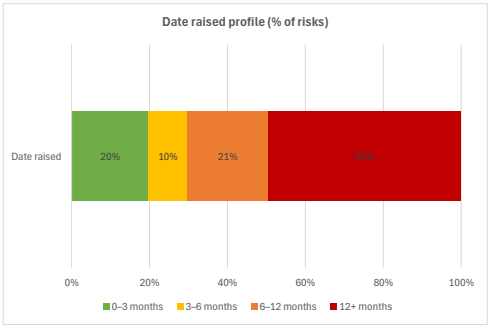
Treatment plans — Overdue 66% (88/134)



Active tasks — Overdue 67% (2/3)



Date raised — 12+ months 50% (50/101)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	2%	17%	48%	34%

Metric	Overdue	In Date
Review dat	75%	25%

Metric	Treat	Tolerate
Risk respo	92%	8%

Metric	Overdue	In Date
Treatment	66%	34%

Metric	Overdue	In Date
Active task	67%	33%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	20%	10%	21%	50%

Surgical

Current Score

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Count	8	121	62	10	201

Review

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	2	35	43	7	87
In Date	6	86	19	3	114

Treat or Tolerate

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Treat	0	31	49	10	90
Tolerate	8	90	13	0	111

Active Treatment plans

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	26	37	10	73
In Date	1	23	33	4	61

Active Tasks

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
Overdue	0	2	3	0	5
In Date	0	2	0	0	2

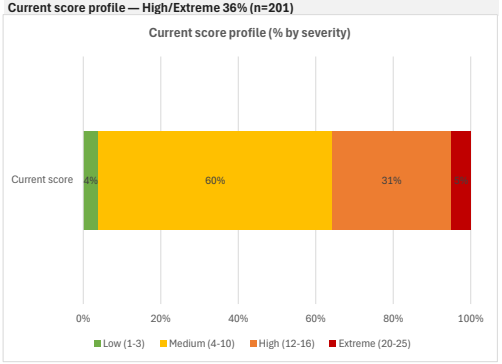
Date Raised

	Low (1-3)	Medium (4-10)	High (12-16)	Extreme (20-25)	Total
0 - 3 months	0	9	8	0	17
3 - 6 months	1	29	24	2	56
6 - 12 months	7	22	9	0	38
12+months	0	61	21	8	90

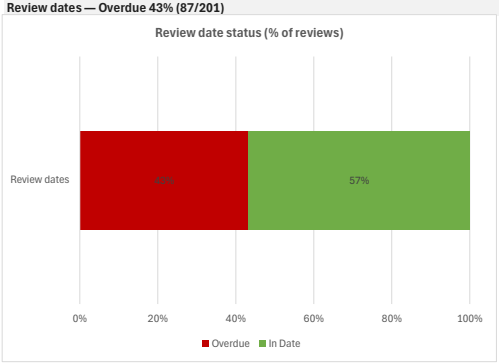
Surgical — board-deck chart review

All charts use percentages for comparability; source counts are included in the chart headings.

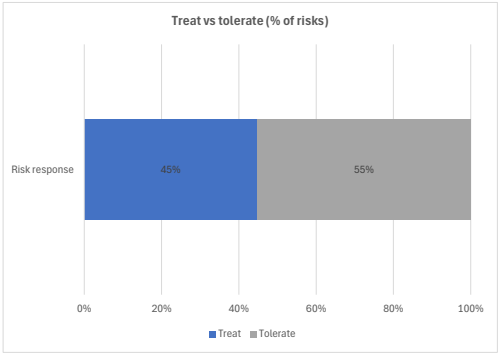
Current score profile — High/Extreme 36% (n=201)



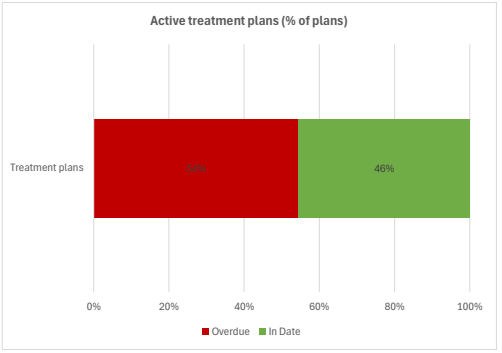
Review dates — Overdue 43% (87/201)



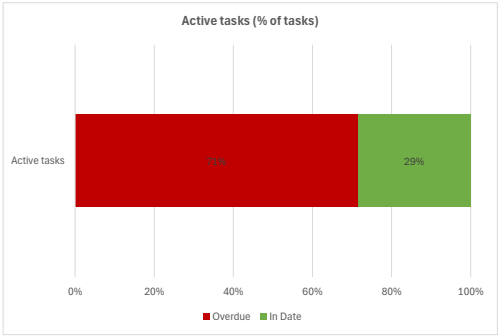
Treat vs tolerate — Treat 45% (n=201)



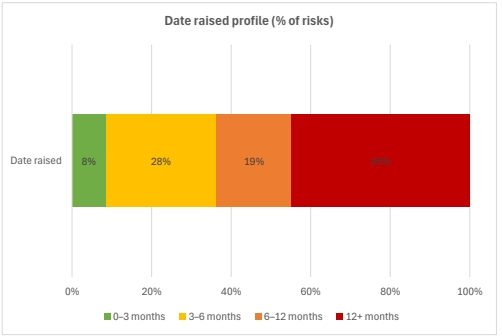
Treatment plans — Overdue 54% (73/134)



Active tasks — Overdue 71% (5/7)



Date raised — 12+ months 45% (90/201)



Metric	Low (1-3)	Medium (4	High (12-1	Extreme (20-25)
Current sc	4%	60%	31%	5%

Metric	Overdue	In Date
Review dat	43%	57%

Metric	Treat	Tolerate
Risk respo	45%	55%

Metric	Overdue	In Date
Treatment	54%	46%

Metric	Overdue	In Date
Active task	71%	29%

Metric	0–3 month	3–6 month	6–12 mont	12+ months
Date raise	8%	28%	19%	45%

	A	D	E	F	G	I	M	Q	V	W	X	Y	Z
1	**Risk title**	**Risk owner**	**Risk event**	**Risk cause**	**Risk effect**	**Initial rating score**	**Current rating score**	**Target rating score**	**Key controls**	**Assurance on controls**	**Gaps in controls**	**Treatment plan**	**Barriers**
2	Length of Stay	EDs Nursing and Medicine	Patients remain in hospital longer than clinically necessary.	Patient-flow and discharge processes are not consistently optimised; related risks identify limited MDT collaboration, therapy capacity, senior decision-maker availability, medicines support and onward-care capacity.	Avoidable harm including deconditioning, poorer experience, delayed admission for other patients, capacity constraint and additional cost.	20	20	8	Daily bed-management and flow meetings; discharge planning from admission; specialty trajectories; outlier MDT huddles; DTOC review; therapy prioritisation; escalation routes; medicines-support pathways.	Proposed assurance: weekly length-of-stay and stranded-patient trends; discharge-delay reason analysis; outlier volumes; readmissions; harm reviews; actions and escalation evidenced through governance minutes.	Variable MDT participation; therapy and senior decision-maker capacity; medicines-support variation; delayed onward-care placements; inconsistent real-time data.	Standardise discharge pathways and escalation triggers; establish skilled outlier MDT support; validate delay reasons; address therapy and medicines bottlenecks; track recurring constraints to closure.	Therapy and clinical workforce funding; social-care and housing availability; community pharmacy capacity; cross-organisational dependencies.
3	UHW Estate	DoF	Estate or critical infrastructure failure, or increased infection prevention and control incidents, disrupts care at UHW.	Age, condition and configuration of the UHW estate, with maintenance and replacement needs exceeding available capacity or funding.	Delayed or unsafe care, patient harm, service interruption, reduced staff morale and productivity.	20	20	10	Risk-based planned and reactive maintenance; statutory inspections; fire, water, ventilation and asbestos controls; IPC audits; incident reporting; temporary mitigations; business-continuity and decant arrangements.	Proposed assurance: current condition surveys; critical backlog profile; statutory compliance and IPC audit results; repeat-fault trends; incident and service-disruption data; action closure reported to the relevant committee.	Ageing fabric and plant; repeated environmental failures; capital backlog; constrained decant space; reactive rather than permanent fixes; single points of failure.	Prioritise critical backlog using safety and continuity criteria; agree permanent remedies for repeat failures; protect critical plant; test decant and continuity plans; monitor delivery and residual risk.	Capital affordability; limited decant capacity; disruption during works; specialist contractor availability; interdependencies across ageing systems.
4	In-year Financial Position	DoF	The organisation fails to maintain control of the in-year financial position and incurs an unaffordable overspend.	Financial planning, forecasting, accountability or delivery grip is insufficient to identify and correct adverse variance promptly.	Funding is diverted from wider public services and the organisation cannot invest or transform as planned.	20	20	10	Monthly financial reporting and forecasting; Standing Financial Instructions; budget-holder accountability; monthly Financial Clearance; weekly Cost Improvement Programme tracker; Executive Performance Reviews; Finance & Performance Committee and Board oversight.	Monthly Monitoring Returns and Welsh Government review; internal audit evidence; forecast accuracy; savings delivery and recurrent/non-recurrent split; cash and payment performance; Targeted Intervention de-escalation evidence.	Gap between planned and recurrent savings; operational cost pressures; forecast uncertainty; limited discretionary spend; delayed delivery of transformation benefits.	Refresh the recovery forecast; assign named corrective actions; validate recurrent savings and benefits; strengthen weekly CIP challenge; escalate adverse run-rate and cash risks promptly.	Demand, inflation and pay pressures; delivery capacity; national funding decisions; non-discretionary expenditure and independent-contractor activity.
5	Clinical Engagement	EDs Nursing, AHPs and Medicine	Strategic and operational decisions are made without sufficient clinical leadership or engagement.	Healthcare professionals are not consistently enabled, activated or aligned to population needs and transformation priorities.	Decisions may not be clinically informed or in the population's best interests, and workforce support for transformation may be lost.	16	12	6	Clinical boards and professional forums; multidisciplinary governance; clinical input to pathway and transformation design; quality-impact assessment; defined escalation and consultation routes.	Proposed assurance: attendance and representation by profession/service; decision logs showing how clinical advice influenced outcomes; action closure; staff survey and engagement feedback; quality and transformation benefit measures.	Uneven participation; limited protected leadership time; unclear decision rights; inconsistent feedback to clinicians; operational pressure and change fatigue.	Define a Trustwide clinical-engagement standard; protect leadership time; require clinical sign-off for material changes; track representation, influence and closed feedback loops.	Operational pressure; change fatigue; workforce availability; competing professional priorities.
6	Lost to Follow-up	COO	A patient is not followed up after a diagnostic result, referral, review or other clinically significant event.	Follow-up pathways are fragmented and reliant on manual hand-offs, lists and document movement; ownership, timeframes and escalation are not consistently defined or auditable.	Crucial information is missed, causing delayed diagnosis or treatment and avoidable patient harm.	20	20	10	Monthly extracted follow-up lists; patient flags until outcomes are completed; SOPs and defined timeframes; RTT validation; results acknowledgement; overdue-case exception reports; clinical escalation and harm review.	Proposed assurance: monthly overdue volumes and ageing; completion rate within standard; audit of acknowledgement and outcome coding; incident and harm-review trends; evidence that exceptions and actions are closed.	Manual processes; multiple systems; large follow-up cohorts; inconsistent outcome recording; weak end-to-end ownership; incomplete performance data.	Implement closed-loop tracking with accountable owner and deadline at each hand-off; reconcile backlog; automate alerts and escalation; audit high-risk pathways and report confirmed harm.	System interoperability; data quality; workforce capacity; legacy backlogs; cross-provider dependencies.
7	Diagnostic Delays	COO	Diagnostic investigation or reporting is delayed, delaying clinical decision-making and treatment.	Demand exceeds sustainable capacity and pathways are constrained by specialist workforce, equipment availability, reporting backlogs, referral quality and variable flow across modalities.	Disease may progress, outcomes and experience worsen, and patients may suffer avoidable harm.	20	20	10	Clinical prioritisation and urgent-suspected-cancer flags; waiting-list validation; extended working; outsourcing/insourcing; pathway-flow changes; urgent-case MDT escalation; turnaround and backlog reporting; harm reviews.	Proposed assurance: modality-level demand, capacity, backlog and longest-wait trends; reporting turnaround; urgent-case compliance; outsourcing performance; incidents, concerns and completed harm reviews.	Specialist workforce shortages; reporting bottlenecks; equipment downtime; rising demand; incomplete demand-and-capacity modelling; variable referral and pathway productivity.	Complete modality-level demand-and-capacity analysis; recover longest waits; protect urgent pathways; optimise reporting flow; address equipment resilience; strengthen prospective harm surveillance.	Specialist workforce shortages; equipment and estate constraints; funding; sustained demand growth.
8	Digital Immaturity	Dir Digital	Digital systems fail to support integrated, reliable and efficient care processes.	Systems are aged, unintegrated or absent, with inconsistent data standards and continued reliance on manual processes.	Data may be incorrect or isolated, services become less effective and efficient, and delivery costs and time increase.	16	16	6	Digital architecture and prioritisation governance; legacy-system and dependency register; SOPs and data ownership; secure communication; change control; staff training and competency; clinical validation; data-quality and benefits monitoring.	Proposed assurance: maturity and architecture assessment; end-of-life technology profile; outage and incident trends; data-quality audits; training and competency records; adoption, benefits and action-closure reports.	End-of-life systems; manual and paper-based work; unsupported technology; incomplete integration; unclear data accountability; constrained digital skills and investment.	Agree target architecture; prioritise high-risk legacy replacement and integrations; establish data owners and standards; digitise high-risk manual workflows; track adoption, benefits and residual dependencies.	Capital and revenue affordability; supplier capacity; workforce readiness; implementation disruption.
9	Cyber Security	Dir Digital	A cyber incident compromises the confidentiality, integrity or availability of information, systems or digital services.	Cyber threats are increasing in volume, sophistication and persistence, while technical or human vulnerabilities remain.	Patient safety, operational performance, privacy and regulatory compliance are adversely affected.	25	20	10	Security monitoring; asset inventory; access controls and MFA; vulnerability and patch management; segregated and tested backups; supplier assurance; staff awareness; incident response integrated with business continuity and disaster recovery.	Proposed assurance: penetration and vulnerability tests; critical-patch and MFA coverage; phishing results; backup restoration tests; cyber exercise outcomes; response and recovery times; supplier remediation and governance action closure.	Legacy and end-of-life technology; untested plans; incomplete asset visibility; third-party exposure; patching constraints; limited specialist on-call and response capacity.	Remediate critical vulnerabilities; complete asset inventory and MFA rollout; exercise cyber response and recovery; integrate plans with organisational continuity; strengthen supplier controls and on-call resilience.	Legacy-system dependencies; specialist skills; funding; supplier responsiveness; operational downtime constraints.
10	Fragile Services	ED Medicine	A small or specialist service cannot sustain safe capacity and capability as demand grows.	The service relies on scarce specialist skills, limited workforce resilience and vulnerable processes or infrastructure.	Patient choice or access is restricted, continuity deteriorates and patients may experience avoidable harm.	20	20	8	Consistent fragility assessment; workforce and succession plans; vacancy and demand monitoring; cross-cover and network arrangements; escalation triggers; service-continuity plans; prioritisation of high-risk pathways.	Proposed assurance: vacancy and turnover trends; single-person dependencies; waiting times and activity loss; cancelled or restricted services; continuity tests; network capacity; delivery of recruitment and succession actions.	Single-handed services; specialist vacancies; sickness and leave vulnerability; long recruitment and training lead times; insufficient cross-cover; rising demand and limited alternatives.	Apply the fragility framework to all priority services; identify single points of failure; agree networked and cross-cover models; develop succession pipelines; test continuity and escalation arrangements.	Vacancy controls and financial constraints; national workforce shortages; training lead times; geography; partner capacity; staff burnout and retention.

	A	D	E	F	G	I	M	Q	V	W	X	Y	Z
11	Accreditation Compliance	ED AHPs	A service loses, fails to obtain or cannot maintain required accreditation.	Changing accreditation standards exceed available capacity, capability or the suitability of the physical environment.	Services operate without accreditation or cease, causing poor outcomes, restricted access and reputational damage.	20	20	10	Accreditation inventory and accountable leads; QMS aligned to each standard; SOP, audit, competency and document control; non-conformance and change-control tracking; multidisciplinary governance; capital and environmental action plans.	Proposed assurance: accreditor correspondence and external assessments; previous accreditation/licensing; internal audit and Q-Pulse reports; non-conformance ageing and closure; competency records; outcome benchmarking; committee oversight.	Known infrastructure and environmental non-compliance; incomplete accreditation inventory; limited quality-resource capacity; overdue audit or change-control actions; investment dependency.	Confirm every accreditation and deadline; risk-rank non-conformances; protect QMS capacity; close overdue actions; deliver required estate schemes; maintain commissioner and accreditor engagement.	Capital and revenue investment; estate limitations; specialist quality workforce; competing transformation programmes; external accreditor and commissioner timescales.
12	Commissioning Architecture	DoF	Commissioning arrangements fail to define and secure services that meet population needs.	Internal and external commissioning architecture is inconsistent and under-developed, with unclear standards, requirements and accountability.	Access to appropriate care is limited, resources are poorly aligned and patients may experience harm.	16	12	8	Commissioning operating model; population-needs assessment; contracts and service specifications; agreed standards and outcomes; finance/clinical/commissioner review; performance escalation; individual funding route only as a controlled exception.	Proposed assurance: specification coverage; access and equity by geography; out-of-area activity; outcome and waiting-time metrics; contract performance; funding alignment; actions and escalations through partnership governance.	Unclear roles and accountability; services without formal funding; inconsistent specifications; fragmented outcome data; reliance on case-by-case approval; cross-organisational dependencies.	Map all uncommissioned or inconsistently commissioned pathways; agree responsibilities and standards; formalise funding and specifications; monitor equity, access, outcomes and exceptions.	Commissioner and partner agreement; financial constraints; statutory boundaries; data availability; contracting capability and alternative-provider capacity.
13	NICE Guidance and Drug Costs	ED Medicine	Implementation of NICE-recommended therapeutics creates unaffordable growth in drug expenditure and displaces other care.	NICE technology appraisals and AWMSG requirements, Drug Tariff and concessionary-price volatility, shortages, prescribing-volume growth and service transfers increase expenditure faster than funding and delivery capacity.	Drug expenditure exceeds allocation; savings options narrow; access may become inequitable; mandated therapies displace other treatment or service investment; unsupported implementation may create long waits and clinical risk.	20	16	12	Medicines horizon scanning; formulary and Medicines Management governance; monthly finance review; tariff and shortage monitoring; value-based prescribing and waste reduction; procurement; uptake and pathway-capacity planning.	Proposed assurance: national medicines analytics; budget variance and forecast accuracy; uptake against NICE/AWMSG assumptions; audit against clinical guidance; procurement and switch savings; outcomes and governance action closure.	Tariff and concessionary-price volatility; mandatory access requirements; uncertain uptake; limited non-detrimental savings; insufficient pathway capacity; late funding decisions.	Maintain a rolling medicines and NICE pipeline forecast; align finance, pharmacy and clinical capacity plans; optimise procurement and formulary use; audit outcomes, equity, uptake and variance monthly.	National guidance timing; market pricing and shortages; patient demand; funding allocations; limited alternatives; workforce and service capacity needed for safe implementation.
14	Culture	CEO and ED People and Culture	The organisation's culture is not optimised to support consistently high-quality service delivery.	Practices and standards are applied inconsistently across a large and diverse workforce, while variable leadership behaviours, morale, motivation, engagement and psychological safety limit ownership and continuous improvement.	Standards of care, patient experience and staff experience may vary or deteriorate, resulting in avoidable harm, poorer outcomes, reduced productivity and loss of public confidence.	20	16	8	Values and behaviours framework; Board and executive leadership expectations; workforce policies and professional standards; recruitment, induction, appraisal and leadership development; staff survey and pulse checks; Freedom to Speak Up and grievance routes; wellbeing and occupational-health support; incident, complaint and quality-governance review; equality and inclusion arrangements.	Proposed assurance: staff survey and pulse results by service and protected characteristic; engagement and psychological-safety measures; appraisal and mandatory-training compliance; turnover, sickness, vacancies and retention; speaking-up, grievance and disciplinary themes; patient complaints, incidents and quality outcomes; triangulated hotspots, action closure and sustained improvement reported through People and Quality governance.	Inconsistent local practices and standards; variable leadership behaviours and accountability; uneven staff engagement and psychological safety; low morale or change fatigue in pressured services; limited triangulation of workforce and quality data; actions may not be evaluated for impact.	Define and embed a Trustwide culture and behaviours standard linked to high-quality care; set measurable expectations for leaders and teams; identify hotspots through triangulated workforce, safety and patient-experience data; require local improvement plans with named owners and deadlines; strengthen speaking-up feedback; evaluate whether actions improve culture and care outcomes.	Operational and financial pressure; workforce shortages and turnover; leadership capacity; change fatigue; variation between services and professions; fear of speaking up; time required for behavioural change; difficulty attributing quality outcomes directly to culture.
15													

Report Title:	Counter Fraud Progress Report				Agenda Item No:	4.2	
Meeting:	Audit & Assurance Committee	Public	X		Meeting Date:	01.09.2026	
		Private					
Status	Assurance		Approval		Information/Noting		X
Lead Executive Title:	Catherine Phillips – Executive Director of Finance						
Report Author Title:	Henry Bales – Counter Fraud Manager						

Main Report
Background and Current Situation:

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.

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

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.

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

Counter Fraud Progress Report

Recommendations:

a) The committee are requested to: note the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

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

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention	x	Long Term	x	Integration		Collaboration	x	Involvement	x

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes		No	x	n.a

Impact Assessment Please place an "x" in the below boxes where relevant
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
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
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 - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: Yes/No
Decarbonisation: Yes/No
Welsh Language: Yes/No

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

Counter Fraud Progress Report

29/04/2026 – 16/08/2026

Public

HENRY BALES
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction

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

This report relates to activity for the reporting period 29/04/2026 – 16/08/2026.

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. A proposal to mandate this e-learning has been submitted to the Education, Culture and Organisational Development team, and the outcome is awaited.

Awareness Sessions – The Counter Fraud team continues to participate in corporate induction events for new starters. During this period, four sessions have taken place, with short counter fraud awareness talks delivered to all attendees, reaching approximately 120 members of staff.
Departmental talks have also been delivered to two departments during this period, reaching a total of 31 members of staff.

SharePoint News Articles – During this period, three news articles have been shared on the Counter Fraud SharePoint site: June Counter Fraud Newsletter, Expenses Fraud – Claim them Right, and NHS Wales Fighting Fraud Strategy 2026-30. Links to these articles are provided below. Users will need to be logged in to an NHS Wales Microsoft account to access them.

June 2026 - Counter Fraud Newsletter

Expense Fraud - Claim Them Right

NHS Wales Fighting Fraud Strategy 2026–2030

Prevention

IBURN/Alerts (intelligence bulletins) – (2)

Two bulletins were received during this period and related to payment diversion fraud and mandate fraud. No CAVUHB-specific concerns were identified. The NWSSP Counter Fraud team has taken these bulletins forward to Accounts Payable.

National Fraud Initiative

Preparations are underway for the 2026/27 NFI exercise. All necessary declarations and steps have been taken to date in preparation for this year's exercise.

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, 34 referrals were made to the team. Of these, six have been promoted to investigation. A further four referrals, which were at the initial review stage at the end of the previous reporting period, have also been promoted to investigation, as detailed in the next section. Three referrals remain at the initial assessment stage, and the remaining referrals have been closed.

Investigations

During this reporting period, 10 investigations were commenced by the Counter Fraud team. Seven investigations were closed during the same period. This means that there are currently 13 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.

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/26/01801	Equipment Theft	03/06/2026		
INV/26/01903	Equipment Theft	11/06/2026	11/06/2026	Duplicate referral
INV/26/02081	Working elsewhere whilst sick	24/06/2026	07/07/2026	No fraud found
INV/26/02123	Qualification Fraud	29/06/2026	01/07/2026	No fraud found.
INV/26/02156	Patient - false details	01/07/2026		
INV/26/02219	False sickness	07/07/2026		
INV/26/02450	Timesheet Fraud	27/07/2026		
INV/26/02711	Overseas Patient	12/08/2026		
INV/26/02719	Leave fraud	13/08/2026		
INV/26/02720	Roster Fraud	13/08/2026		

Investigations closed in the period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/25/02172	Working elsewhere whilst sick	CARRIED OVER - 14/07/2025	30/04/2026	Disciplinary Outcome
INV/26/00890	Working elsewhere whilst sick	CARRIED OVER - 11/03/2026	07/07/2026	No fraud found
INV/26/00979	Accessing records	CARRIED OVER - 23/03/2026	30/04/2026	Disciplinary Outcome
INV/26/01166	Overseas Patient	CARRIED OVER - 31/03/2026	30/04/2026	No fraud found, intelligence noted
INV/26/01903	Catering Equipment Theft	11/06/2026	11/06/2026	Duplicate referral
INV/26/02081	Working elsewhere whilst sick	24/06/2026	07/07/2026	No fraud found
INV/26/02123	Allegation of no qualification	29/06/2026	01/07/2026	No fraud found.

Investigations that remain open

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/01634	Salary Sacrifice Vehicle - Payments not made	CARRIED OVER - 03/08/2023		
INV/23/02002	Theft of Medication	CARRIED OVER - 15/09/2023		
INV/24/00462	Working elsewhere whilst sick	CARRIED OVER - 21/02/2024		
INV/25/02716	Prescription Fraud	CARRIED OVER - 15/09/2025		
INV/26/00131	Prescription Fraud	CARRIED OVER - 15/01/2026		
INV/26/01340	Prescription Fraud	21/04/2026		
INV/26/01801	Equipment Theft	03/06/2026		
INV/26/02156	Patient - false details	01/07/2026		
INV/26/02219	False sickness	07/07/2026		
INV/26/02450	Timesheet Fraud	27/07/2026		
INV/26/02711	Overseas Patient	12/08/2026		
INV/26/02719	Leave Fraud	13/08/2026		
INV/26/02720	Roster Fraud	13/08/2026		

3. Significant Salary Overpayments

There have been five 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.

“Significant” overpayments are defined in the policy as overpayments with a total value of more than £5,000 that 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.