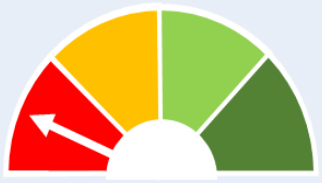
Reducing Health Inequalities – Ethnicity Data

Final Internal Audit Report

2025/26

Cardiff & Vale University Health Board



Unsatisfactory Assurance

Contents

Review Reference	CVU-2526-22
Fieldwork	January - April 2026
Executive Sign Off	August 2026
Audit Committee	September 2026
Executive Lead	Claire Beynon, Executive Director of Public Health
Audit Team	Ian Virgill, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

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Audit and Assurance Services

Executive Summary

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.

The Health Board's vision as outlined in the Health Board's Strategy is, "Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced." Measurement of the health outcomes for different groups is an essential step to reducing health inequalities.

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.

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

Scope & Assurance Summary

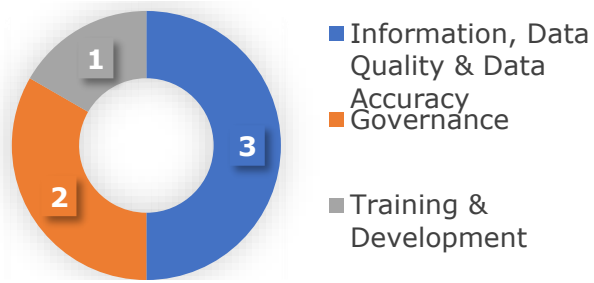
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate arrangements, procedures and systems are in place within the Health Board to enable the effective collection of 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 and that this is used to influence planning and delivery of services	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

Findings & Agreed Action Plan

Objective 1: Appropriate arrangements, procedures and systems are in place within the Health Board to enable the effective collection of ethnicity data	**Limited**

Overview / Summary of Observations

We found that whilst the Health Board has established a strategic framework for equity through the *Equity, Equality, Experience and Patient Safety Framework*, this has not systematically translated into effective operational arrangements for the collection of patient ethnicity data. The framework sets out ambitions to identify inequalities, use intelligence to inform action, and tailor interventions, and progress is reported to the Quality Committee. However, the Annual Equality Report acknowledges that patient equality data remains a long-term challenge due to multiple patient administration systems and inconsistent data capture.

The Health Board's Principal Analyst provided ethnicity data from the Patient Management System (PMS) and the Patient Administration and Record Information System (PARIS) for the period 1st April – 31st December 2025 which was a total of 266,176 patients. This covered Outpatients, Inpatients, Day Cases, Regular Day Attendances (RDAs), and Emergency Unit (EU) at University Hospital of Wales (UHW), Barry Hospital and the Assessment and Treatment Centre and identified that only 19.72% of the total patients had confirmed their ethnicity.

There is a system in place for patients to record their ethnicity data in the Emergency Unit via the e-triage tool that was introduced a couple of years ago. It is a self-registration tool that allows patients to record all their demographics including ethnicity.

Patient ethnicity data is also collected by the Patient Experience team via the CIVICA patient system, which is used to gather feedback from inpatients, outpatients and selected other areas. The survey is designed to incorporate an equality component and is structured into two sections: overall patient experience and an equality monitoring section. Data is collected routinely from patients, after which Patient Experience issues a weekly, auto generated Civica report to the Clinical Boards, including details on the number of ethnic groups the survey was distributed to.

We also note that there is currently no comprehensive register in place within the Health Board of the systems that may be capturing ethnicity data, despite hundreds of clinical applications being operated locally within Clinical Boards. Each of the information assets within the Health Board is expected to have an owner, but it was recognised that the Information Asset Owner roles are largely unfilled. The Information Asset Owner roles were reviewed as part of a previous Cyber Security audit we undertook, where it was noted that the Information Asset Register was also incomplete. This is part of a wider problem within the Health Board and discussions are underway to try and resolve.

Training or guidance for staff on the importance of obtaining patient ethnicity data has not been developed, issued or delivered. Staff report feeling uncertain about asking questions and how this data is used to inform plans.

	Key Findings	Risk & Impact	Agreed Management Action
1	**No comprehensive register of systems capturing ethnicity data** The Health Board does not maintain a comprehensive, central register of systems that capture patient ethnicity data. Although certain corporate systems (e.g. PAS, PMS, PARIS, Clinical Portal)	Incomplete understanding of where ethnicity data is collected and stored.	**Agreed Action:** Management will develop a system register covering all known corporate systems that capture ethnicity and protected characteristics data.

	are known, there are hundreds of locally managed clinical applications within Clinical Boards, many of which are not inventoried and may collect ethnicity information inconsistently.	Increased risk of duplication and uncontrolled local data practices.	**Expected Evidence of Implementation:** Approved system register document.
		High Priority	**Suggested Officers:** Director of Digital and Health Intelligence **Target Implementation Date:** April 2027
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
2	**No training or guidance for staff on patient ethnicity data collection** The Health Board has not developed or delivered specific training or provided guidance for staff involved in collecting, recording, or handling patient ethnicity data or other protected characteristics.	Inconsistent data collection and recording practices.	**Agreed Action:** Management will develop targeted guidance for frontline and administrative staff on the importance and appropriate techniques to collect protected characteristics including ethnicity data within the Health Board. The guidance will then be sign posted as part of the Equality, Diversity and Human Rights training module. Each Clinical Board will have visibility of the percentage of their staff who are compliant with the mandatory Equality, Diversity and Human Rights training.
			Expected Evidence of Implementation: • Training materials produced on importance and appropriate collection methods for protected characteristic information. • Training completion records reported by Clinical Board and reported to People and Culture Committee annually as a minimum.
		Medium Priority	**Suggested Officer:** Executive Director of People and Culture **Target Implementation Date:** November 2026
	Theme: Training & Development	Control Design	

Objective 2: There are adequate quality assurance checks to ensure that data collected is complete and accurate	**Unsatisfactory**

Overview / Summary of Observations

The audit identified gaps in quality assurance arrangements for patient ethnicity data. Without a system register identifying where ethnicity data is held, the Health Board cannot apply consistent validation or assurance controls across its data landscape.

Incomplete records of ethnicity data undermine the reliability to quality assure the data for any form of analysis, planning or reporting. Until this is resolved and established, the Health Board will be unable to accurately measure improvement or demonstrate progress in addressing health inequalities.

Key Findings		Risk & Impact	Agreed Management Action
3	**No quality assurance framework for ethnicity data** There is no formal quality assurance framework in place for assessing the completeness or accuracy of the patient ethnicity data that has been collected or checking the integrity of the data as it is collated. There are no baseline completeness thresholds, validation controls, or routine checks in place for monitoring data quality. While strategic frameworks such as the *Equity, Equality, Experience and Patient Safety Framework* exist, operational accountability for ethnicity data is fragmented across Clinical Boards and corporate teams, with Information Asset Owner (IAO) roles largely unfilled in practice. As a result, there is no clear ownership of data standards, completeness, or improvement actions.	Ethnicity datasets are unreliable for analysis, planning, or reporting. Reputational risk if the Health Board cannot demonstrate progress on health inequalities. Inability of the Board to measure progress towards reducing health inequalities.	**Agreed Action:** Lead staff in each Clinical Board will be identified to boost completeness of data on protected characteristics, to undertake quality assurance checks and implement routine completeness and exception reporting to ensure data is complete and accurate. Ensure Information Asset Owner roles for systems capturing patient ethnicity are fully assigned and embedded within the Clinical Boards. **Expected Evidence of Implementation:** Documented data quality framework. Regular data quality reports with defined thresholds. Reports from the Clinical Boards to Committee and Board to contain data on ethnicity and other protected characteristics of patients as standard. Updated Information Asset Owner register identifying responsible owners for relevant ethnicity recorded and related systems.
		High Priority	**Officer:** Chief Operating Officer **Target Implementation Date:** April 2027
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Effective processes are in place to ensure effective utilisation and reporting of the ethnicity data within the Health Board to drive effective decision making	**Unsatisfactory**

Overview / Summary of Observations

We found that patient ethnicity data is not effectively utilised, monitored, or reported for strategic or governance purposes. While ethnicity data is collected in some systems and surveys, it is not integrated into a consolidated system. There is no evidence of routine ethnicity reporting within key governance forums.

Ownership and accountability for the strategic use of ethnicity data are unclear. Consequently, despite the Health Board's stated commitment to reducing inequalities, the organisation does not have an oversight of ethnicity data and is therefore unable to demonstrate its commitment, which limits assurance to the Board and constrains the organisation's ability to demonstrate effective delivery against its equality objectives.

We also note that the Equity, Equality, Experience and Patient Safety Action Plan update presented in April 2026 at the Quality Committee included an action within the Analytics action area for 'Identification of potential indicators and development of an equity dashboard'. An update on the current position from the Consultant in Public Health Medicine within the local public health team confirmed that the health equity dashboard is at an early stage of development, with identified indicators but limited data availability. The dashboard is yet to be built or made operational, it remains on a list to be developed and has not been prioritised due to competing demands in the digital team.

Analysis has been undertaken by the Quality Committee following a review of Welsh Index of Multiple Deprivation (WIMD) in 2025 which showed no difference in wait time by socio-economic status.

We are aware that there are reports produced on staff ethnicity data.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Absence of clear ownership and accountability for ethnicity data collection** The Health Board has designated Board Champions for each of the protected characteristics. The Chief Executive is the Board Champion for ethnicity.	The Health Board is unable to demonstrate effective governance over equality data, potentially undermining statutory equality duties and health inequalities objectives as set out in the organisational strategy.	**Agreed Action:** Management will: • Reinstate and refresh the Board Champion role expectations for ethnicity and other protected characteristics across the Executive Team with clear objectives and tasks assigned as part of the Champion role. **Expected Evidence of Implementation:** • Board Champion for ethnicity to champion ethnicity data collection for patients and check Committee papers for evidence of presentation of information as standard. • Board Champions for other protected characteristics to champion data collection for patients and check

			Committee papers for evidence of presentation of information as standard.
		High Priority	**Officer:** Executive Director of People and Culture **Target Implementation Date:** November 2026
	Theme: Governance	Control Operation	
5	**Ethnicity data collected in isolation and not integrated for strategic use and limited use in reporting** Ethnicity data is collected across various sources (e.g. GP registrations, patient experience surveys, immunisation systems, Outpatients, Inpatients, Day Cases, Regular Day Attendances, and Emergency Unit); however, it remains siloed and is not integrated into a single unified, analytical view. While surveys such as Civica collect voluntary equality data, their primary focus is on service satisfaction. Although the survey ethnicity data is collected, analysed and provided to Clinical Boards on a weekly basis, it is not consolidated to support broader monitoring or strategic reporting of the data beyond the routine reports issued to the Clinical Boards. Patient ethnicity data is currently not monitored or reported within the Health Board governance structures. Reviews of Quality Committee and People and Culture Committee papers showed no reference to patient ethnicity monitoring or reporting during the last 9-month period reviewed.	Inability to triangulate data across care pathways. Missed opportunities to identify and address health inequalities. Weak assurance to the Board on delivery of equality objectives.	**Agreed Action:** Management will direct the Clinical Boards to undertake reporting and review of routine data with a focus on ethnicity and other protected characteristics as a standard part of any reporting.
			Expected Evidence of Implementation: Documented evidence showing ethnicity data and data on protected characteristics is used to make service decisions and service changes in any papers for decision making to Strategic Leadership Team, Committee and Board papers and Business Cases.
		High Priority	**Officer:** Deputy Chief Operating Officer **Target Implementation Date:** December 2026
	Theme: Governance	Control Operation	
6	There is potential that data could be linked between either primary and secondary care or via Secure Anonymised Information Linkage data set (SAIL) that would improve the data quality and coverage of ethnicity and other protected characteristics, this would improve data quality.	The Health Board cannot undertake high quality planning with limited data.	**Agreed Action:** Management will investigate the option of data sharing between primary and secondary care of protected characteristics data. Management will investigate the linking of data via the Secure Anonymised Information Linkage data set (SAIL) All newly developed patient related systems will include questions on protected characteristics, and input controls to ensure these are completed before patients can proceed to the next stage.
			Expected Evidence of Implementation:

			Data linkage agreed and funded, and data quality rises from currently 20% for ethnicity to more than 80%. This is then expanded to other protected characteristics.
		High Priority	**Officer:** Medical Director **Target Implementation Date:** December 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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