Inspection Title	External Inspection Lea	Inspection Date	Recommendation	Reference Number	Action	Due Date	Last Updated	Action Rating	Progress Status	Audit Committee	Risks	Barriers	Comments/Updates
Implementation of National IT Systems (WNCR)	Director of Digital and Health Intelligence	25/10/2022	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	Corporate Governance - Internal Audit/2022/266/MD1/1	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue. The process established includes: • Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work; • Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; • Informal executive to executive meetings planned for every 3 months.	30/06/2025	11/11/2025	Amber	Fully complete (Approved)	08/11/2022			July 2024 IA tracker update: June 2024 - WNCR continues to progress from a Digital point of view with the deployment of the first 50 iPads and testing. The rest of the devices are scheduled to be deployed subject to approval of testing in Q2/3 2024. March 2025 - WNCR roll out anticipated to complete in June 2025. CAV requirements relating to WNCR programme are managed through national service management board. Oct 2025: The last update references Digital Director three monthly updates on progression. I do not attend these meeting and have not been involved in any of these conversations or arrangements. This task can either be closed or should be transferred to David Thomas as ongoing. Nov 2025 - Director of Digital & Health Intelligence has confirmed that this action can be closed.
Capital Systems 2023/24	Executive Director of Finance	25/10/2023	Project officers should ensure that returned contracts and Chair's action are signed, initialled, and dated consistently.	Corporate Governance - Internal Audit/2023/306/MD1/1	Guidance will be issued across the Project Management and Executive cohort to remind approvers of the importance of clearly dating formal documents when signing.	31/10/2023	07/11/2025	Amber	Fully complete (Approved)	06/02/2024			Guidance has been issued to Project Manager to check contracts are dated, documents are processed via docusign before orders are raised with senior management authorisation.
Capital Systems 2023/24	Executive Director of Finance	25/10/2023	Project Issues Form's will be completed for all project changes to demonstrate compliance with delegated limits.	Corporate Governance - Internal Audit/2023/306/MD4/1	Agreed – the Health Board have already commenced transitioning to this approach.	30/09/2023	07/11/2025	Amber	Fully complete (Approved)	06/02/2024			Project Issue Forms are completed on a not to exceed basis prior to works being undertaken by a external cost advisor, forms have been updated with the delegated limits
LIMITED - Estates Condition	Executive Director of Finance	24/01/2024	1.1 - The lead executive should approve the proposed approach to the surveys, recognising any benefits/limitations of the approach taken 1.2 Surveys should be carried out on the UHB estate with the results informing both an updated estates strategy and EFPMS returns	Corporate Governance - Internal Audit/2024/309/MD1/1	Agreed - Condition surveys were tendered in November 2023. The tenders received did not provide a competitive response. Therefore, the tender is being re-issued in Jan 2024. It is anticipated that the surveys and completion of the reports will not be achieved until July 2025.EFPMS will continue to be updated, until after the condition survey update, using informed data.	29/02/2024	07/11/2025	Amber	Fully complete (Approved)	06/02/2024			Dec 2024 - Funding has been approved for the commencement of the Business Case Enabling Works to provide information on the UHB Buildings to support and inform future Business Case developments. The surveys are due to commence in January 2025.
LIMITED - Estates Condition	Executive Director of Finance	24/01/2024	The Estate strategy should be updated to reflect items including performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	Corporate Governance - Internal Audit/2024/309/MD2/1	Agreed in principle - The estates strategy has constantly been reviewed, with many aspects within the document updated to provide responses to previous Board queries and the Welsh Government requests. The condition survey findings will help inform the direction of investment in relation to backlog maintenance, space utilisation, functional suitability and investment strategies. This information, along with reviewing the IMTP of clinical departments and the strategic direction of the Board will help inform the Estates Strategy.	31/03/2024	07/11/2025	Amber	Fully complete (Approved)	06/02/2024			Dec 2024 - Funding has been approved for the commencement of the Business Case Enabling Works to provide information on the UHB Buildings to support and inform future Business Case developments. The surveys are due to commence in January 2025. The completion of the 2024/25 IMTP will also help inform the prioritisation of capital investment within the UHB Estate.
Technical Continuity	Director of Digital and Health Intelligence	24/01/2024	Ivanti should be further developed to include fields for recording of the detail of a root cause analysis and for improvement actions. A formal procedure or guide for incident handling should be developed.	Corporate Governance - Internal Audit/2024/308/MD7/1	7.1 - Confirm or create method for capturing root cause analysis within Ivanti Service Desk. Provide updated documentation for Incident Management.	01/04/2024	17/06/2026	Green	Fully complete (Approved)	28/10/2025			Aug/Sept - 2025 - Conversations continue about the process to capture Root Cause for major Incidents with Ivanti. P1 and P2 reports and RCA are now included manually. July 2024 IA tracker update: Mar 2024 - Root Cause is being captured as part of the normal Problem Management process. This is being enhanced with a more specific data collection post Major Incidents and Problems. These changes will be update in the Incident and Problem Management documentation. - Q1 2024
University Hospital Llandough Endoscopy Development	Executive Director of Strategic Planning	26/02/2024	The UHB should liaise with NWSSP Accounts Payable to highlight the importance of project payments being made in line with contractual terms, and identify whether a solution is feasible.	Corporate Governance - Internal Audit/2024/746/MD13/1	Agreed. Contact will once again be made.	31/01/2024	07/11/2025	Amber	Fully complete (Approved)	20/05/2024			Discussed with CEF Business Manager and NWSSP appointed lead to ensure AP are briefed on the importance of meeting payment certificate dates.

University Hospital Llandough Endoscopy Development	Executive Director of Strategic Planning	26/02/2024	On completion of the project, management should undertake a review of how the design / change process has been managed, with any lessons learnt identified for application at future projects.	Corporate Governance - Internal Audit/2024/746/MD14/1	Agreed. The Project Director has already challenged the number of PIFS raised at this project and requested a postproject review. However, it is important to note the project remains within budget and the finished product will meet the service requirements. The approach taken was tailored to the style of the project contractor. We are also reviewing our approach to budget management with this Contractor: preparing our own estimates rather than awaiting the Contractor to cost the PMIs. This will improve our ability to make informed decisions based on greater cost certainty surrounding.	31/01/2024	07/11/2025	Amber	Fully complete (Approved)	20/05/2024			This has now been actioned with not to exceed budget estimates being used on PIFS.
University Hospital Llandough Endoscopy Development	Executive Director of Strategic Planning	26/02/2024	The UHB and external Project Manager should support the change management process by completing the following activities in a timely manner: • approving PIFs; • accepting quotes (via PMN); and • ensuring PMNs are not issued until PIFs have been approved.	Corporate Governance - Internal Audit/2024/746/MD15/1	Agreed. As referenced at management response 5.1, we are implementing a new process of forecasting PIF costs internally, rather than awaiting contractor quotations. This will allow a more timely review of the change and likely budget implications, with the instruction issued once the quotation is received and agreed.	31/01/2024	07/11/2025	Amber	Fully complete (Approved)	20/05/2024			The UHB project liaison officer and head of capital planning now ensure that the above processes are all now followed in a timely manner on current Health Board projects.
University Hospital Llandough Endoscopy Development	Executive Director of Strategic Planning	26/02/2024	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	Corporate Governance - Internal Audit/2024/746/MD16/1	1 - Agreed. We have received verbal assurance from the Endoscopy Department that the warranty period is three years, therefore there is no risk to this expiring prior to installation. 2 - Agreed. We recognise this would be an enhancement at future projects, where applicable. 3 - Agreed	31/01/2024	07/11/2025	Amber	Fully complete (Approved)	20/05/2024			1. Equipment warranty was discussed with the supplier and no issue was raised with extending the equipment warranty. 2. Accepted, to be monitored on future projects. 3. Accepted, to be actioned on future projects.
University Hospital Llandough Endoscopy Development	Executive Director of Strategic Planning	26/02/2024	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	Corporate Governance - Internal Audit/2024/746/MD17/1	1 - Agreed. We have commenced maintenance of KPIs, based on the Designed for Life Framework as a starting point, and will work on enhancing this process as it progresses. The process includes reporting to the Director of Capital & Estates, with an escalation process where needed. 2 - Agreed - recognising this will be tailored to each project and advisors as appropriate – less complex schemes / appointments can still be managed via the SLA.	31/01/2024	07/11/2025	Amber	Fully complete (Approved)	20/05/2024			KPI's are now included within the Cardiff and Vale 2nd Generation Building works framework that closes off this item. NEC4 PSC are now being considered for use with external advisor appointments.
Cancer Services	Chief Operating Officer	01/05/2024	Management should consider the purpose and operating arrangements of the weekly cancer tracker meetings and clarify these and the roles of those in attendance in documented terms of reference/operating arrangements.	Corporate Governance - Internal Audit/2024/748/MD1/1	Standard Operating Procedure and Terms of Reference documents to be created in collaboration with appropriate clinical board managers outlining the scope and purpose of the cancer tracking meetings. This document should also include a roles and responsibilities component for the relevant Cancer Services and Clinical Board staff.	30/05/2024	21/08/2026	Green	Fully complete (Approved)	20/05/2024			August 2026 - Agreed by Internal Audit that this action can now be closed as the meetings now form part of core business. July 2026 - These meetings have now evolved and have become a regular Tuesday afternoon meeting where tumour sites are able to attend and escalate patients and discuss complex pathways. This is a core business/operational meeting that doesn't necessarily require a TOR or SOP. July 2024 IA tracker update: 1. The existing terms of reference including roles and responsibilities has been recirculated through the Executive Cancer Oversight meeting to reiterate requirements for the daily cancer oversight meeting. The revised terms of reference for the bi weekly cancer tracking meetings are currently in progress. 2. The document will be circulated by COP 14/06/2024. 3. There are no challenges currently affecting the ability to circulate this document.

Cancer Services	Chief Operating Officer	01/05/2024	Arrangements should be put in place to ensure that the business of the Executive Cancer Board is appropriately documented. As a minimum we would expect there to be: • Minutes for each Executive Cancer Board meeting; • Members attendance; • Standing agenda of items to be discussed; and • Log of key actions/decisions from each meeting.	Corporate Governance - Internal Audit/2024/748/MD3/1	The General Manager for Cancer Services will produce a needs requirement paper outlining the administrative support required for the service to deliver on the recommendation to be presented to the Director for Planned and Specialised Care. In the interim, options for administrative support to the Executive Cancer Board will be sought within the current establishment.	01/06/2024	05/01/2026	Amber	Fully complete (Approved)				This action was reviewed in executive cancer board with direction from the COO that there will not be formal minute taking and that a simple form of action taking will suffice
Management of Health Board Policies Follow-Up	Director of Corporate Governance	21/05/2024	1.1 - The draft changes to 'UHB 242 - Written Control Documents - Development and Approval Procedure' which have been prepared to reflect the new arrangements and incorporate the Standing Operating Procedure should be formally reviewed, approved and communicated to relevant personnel. 1.2- The Health Board's website and SharePoint should be reviewed to ensure that they have been appropriately updated, including all links, so that all relevant information is readily and easily available.	Corporate Governance - Internal Audit/2024/909/MD1/1	Policy UHB 242 and UHB 001 prioritised for updates, these will be completed to reflect the new digital process and shared with appropriate personnel throughout the organisation	30/09/2024	09/01/2026	Amber	Fully complete (Approved)				Jan 2026 - UHB-242 Written Control Document Procedure has now been revised to align to the digital process of managing policies on AMAT. A copy of the procedure has been added to this record and the corporate sharepoint page on policies also links to this which can be accessed via https://nhswales365.sharepoint.com/sites/CAV_Controlled%20Document%20Library
IMTP Development Process June 2024	Executive Director of Strategic Planning	14/06/2024	Management should ensure that in future plans are identified to deliver the full annual savings requirement at the point that the MDS is provided to Welsh Government.	Corporate Governance - Internal Audit/2024/831/MD1/1	Stronger emphasis on savings plans up front in the planning process (July -September) and increased scrutiny of the plans earlier in the process (October).	30/09/2024	04/06/2026	Red	Fully complete (Approved)	02/07/2024			04/06/2026 - Internal Audit confirmed this action had been superseded by the Integrated Annual Plan internal audit report from August 2025. 22/10/25 - Whilst there was a stronger emphasis on the savings plan during the planning process with various planning events at UHB level, the UHB submitted an MDS with a gap of c. £8m and therefore did not achieve the recommendation to ensure all savings are identified at the point of submission. This action will continue to be worked towards as part of the 2026/27 planning process.
LIMITED Decarbonisation	Executive Director of Strategic Planning	18/06/2024	1.1 - The Terms of reference for both groups should be reviewed and updated with version control information including date of document and next review date. 1.2 - Meetings should be held in line with the TOR and management should ensure that they are quorate.	Corporate Governance - Internal Audit/2024/925/MD2/1	1.1 - These have been amended and will be shared at the next Decarbonisation Delivery and Working Groups 1.2 - Noted that meetings need to be quorate.	31/12/2025	13/05/2026	Green	Fully complete (Approved)	02/07/2024	15.05.2025 update from Arjun Padmavathy: Without a functioning governance structure, the progress and monitoring of decarbonisation actions have slowed down. This further exasperates the progress in closing emission gap aligned to Welsh Government carbon reduction targets and CAVUHB's carbon reduction target. 29.01.2026 update from Arjun Padmavathy: Given the scope of work and limited resources, the progress is not at an optimum level to close the emission gap.		24.01.2025 update from Edward Hunt: Governance around decarbonisation has been put on hold and is being rethought given its prominence in the SOFW strategy. A new decarbonisation manager has been appointed to provide secretarial support to a future forum. 15.05.2025 update from Arjun Padmavathy: As updated by Edward Hunt previously, the governance around decarbonisation and sustainability was on hold till End of Jan 2025. Since the new sustainability manager joined the governance around sustainability is given shape to. As of now we have established a Sustainability Program Board that provides steering to decarbonisation and climate adaptation projects. Currently sustainability manager is working on establishing a Environment and Climate Response Delivery Group and Clinical Lead 20.05.2025 - date extended to December 2025, as that is when the new Climate Response Plan will be in place. 29.01.2026 update from Arjun Padmavathy: Full governance structure for Sustainability and Climate Response has been established and functioning as expected. Due to SDP refresh timeline a Climate Response Plan will be developed in first quarter of 2026-27. 27/04/2026 - Follow up Decarbonisation Internal Audit has

LIMITED Decarbonisation	Executive Director of Strategic Planning	18/06/2024	Management should ensure that staff complete the sustainability courses on ESR and also raise awareness of the availability of the training modules.	Corporate Governance - Internal Audit/2024/925/MD4/1	We have been advertising the existence of training but as its not mandatory, we have limited influence to make more people do it. An action in the 24/25 action plan is to re-consider making it mandatory.	31/12/2025	13/05/2026	Amber	Fully complete (Approved)	02/07/2024			15.05.2025 update from Arjun Padmavathy: To achieve embedding meaningfully in the culture of the UHB it needs the implementation of a comprehensive behavioural change plan, that changes both staff and organisational behaviour. Currently the Sustainability Manager is working on a Behavioural change plan, and one of the key elements of the plan is establishing feasibility and rolling out relevant training modules. These will be promoted to the staff through a communication plan. The plan's implementation is subjected to Sustainability Program Board approval. 20.05.2025 - date extended to December 2025, as that is when the new Climate Response Plan will be in place. 27/04/2026 - Follow up Decarbonisation Internal Audit has marked 3.1 action as complete: 'Our initial audit highlighted that the number of staff that attended the sustainability courses were low in comparison to the total number of staff within the Health Board. Management has taken steps to promote the sustainability training available on ESR through multiple communication channels, including the Sustainability Pledge campaign, intranet features, Ask Suzanne, and CEO Connect updates. Although, the uptake of sustainability courses remains limited as the courses are not mandatory, the Health Board is awaiting national guidance and the development
LIMITED Decarbonisation	Executive Director of Strategic Planning	18/06/2024	The Health Board should consider creating and maintaining a register of potentially helpful external groups with a Health Board representative for each of them. Furthermore, those attending should provide regular feedback on the group's activity.	Corporate Governance - Internal Audit/2024/925/MD5/1	Noted. The ownership of decarbonisation in the organisation is likely to change over the next six months. A handover document has been created (in draft at the time of writing) and this information and need has been inserted in there.	31/12/2025	13/05/2026	Green	Fully complete (Approved)	02/07/2024			15.05.2025 update from Arjun Padmavathy: Relevant update will be from external meetings are being provided top the program board. 20.05.2025 - date extended to December 2025, as that is when the new Climate Response Plan will be in place. 27/04/2026 - Follow up Decarbonisation Internal Audit has marked 4.1 action as complete: 'The Environmental Sustainability Improvement Manager represents the Health Board on several local, regional, and national groups. We feel it addresses the thrust of our previous matter arising, given that it was a low priority. However, the refresh of the Strategic Delivery Plan (SDP) means that group structures and required representation are still being redesigned. This is being tracked on the delivery group's action log. We were advised that full completion may be challenging as many forums are still evolving or yet to be established.'
Health and Safety 2024	Executive Director of People & Culture	20/08/2024	1.1 - In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, an entry should be made in the live action tracker document containing reasons for the overrun, the redefined target date, and the date of the Health and Safety Sub-Committee meeting to which the revised target date was reported. A record of the original target date and any amendments should be retained for monitoring purposes, and general status updates should also be recorded against all actions that are in progress. 1.2 - In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, a report should be made to the Health and Safety Sub-Committee containing reasons for the overrun and the revised target date.	Corporate Governance - Internal Audit/2024/839/MD1/1	There is a planning meeting with the department leads on 02/09/2024 to discuss the scope of work for a full department down day in November. Revised dates with the leads will be determined in this September meeting along with comments for the overrun. The original dates will be retained. Entries will be made in the live action tracker document containing reasons for the overrun, the redefined target date, and the date of the Health and Safety Sub-Committee meeting to which the revised target date was reported.	15/10/2024	31/12/2025	Amber	Fully complete (Approved)				New dates and reasons for overrun have been added to the live tracker document. This was presented to the H&S committee for assurance on 15/10/2024

Health and Safety 2024	Executive Director of People & Culture	20/08/2024	1.1 - In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, an entry should be made in the live action tracker document containing reasons for the overrun, the redefined target date, and the date of the Health and Safety Sub-Committee meeting to which the revised target date was reported. A record of the original target date and any amendments should be retained for monitoring purposes, and general status updates should also be recorded against all actions that are in progress. 1.2 - In cases where target dates elapse in respect of an action detailed in the Health and Safety Culture Plan, a report should be made to the Health and Safety Sub-Committee containing reasons for the overrun and the revised target date.	Corporate Governance - Internal Audit/2024/839/MD1/2	A report detailing the overrun actions will be presented at the October Health and Safety Committee meeting.	15/10/2024	31/12/2025	Green	Fully complete (Approved)				Report and culture plan presented at the H&S Committee 15/10/2024
Performance Reporting 2024	Director of Digital and Health Intelligence	21/08/2024	Management should ensure the guidance document is finalised and brought into use as it would support in mitigating some of the exceptions highlighted within the report and support the production of a robust IPR.	Corporate Governance - Internal Audit/2024/838/MD2/1	The IPR has changed significantly since the audit in 2021/22. A revised guidance document will be produced to reflect the staff roles/responsibilities, governance arrangements and associated processes for managing under-performance.	30/11/2024	25/08/2026	Green	Fully complete (Approved)	03/09/2024			Aug 2026 - The IPR has now been superseded by a completely different product embracing the Making Data Count principles promoted by NHS Wales. The product is automated through a Data Capture Tool and a Power-BI GUI product where responsibility for data enter, quality control and sign-off is with the Executive teams. Action has been closed down as agreed by Internal Audit in Aug 2026. Sep 2025 - The user guide has been in constant change as the IPR and supporting front page has been changing constantly.
Safeguarding	Executive Nursing Director	07/10/2024	1. The Chair should formally check and confirm that meetings are quorate prior to the start of each meeting, and this should be recorded in the meeting minutes. 2. The membership of the SSG should be reviewed.	Corporate Governance - Internal Audit/2024/837/MD2/1	The UHB are satisfied with the SSG membership, having the Local Authority and police in attendance when they are available is deemed good practice to promote UHB transparency. However, it may need to be clear that attendance by both agencies is not a requirement. The SSG minutes will in future clarify which CB the attendees are representing.	31/10/2024	05/08/2026	Amber	Fully complete (Approved)	24/07/2025			Ensuring that the meeting is quorate is a standing item on each agenda. May's meeting was rescheduled due to there being insufficient representation from Clinical Boards.
Smoking Cessation	Executive Director of Public Health	06/12/2024	Appropriate Resourcing of Hospital Smoking Cessation Service	Corporate Governance - Internal Audit/2024/852/MD1/1	Ahead of the decision on future funding via the business case, the Hospital Smoking Cessation Service and Public Health Team will review collaborative working arrangements to ensure referral and treatment pathways are efficient, appropriate, meet the needs of patients/clients and ensure smooth transition from inpatients to outpatient/community services. Once future funding is established, the two teams will work collaboratively to assess what action is required to optimise resourcing to the Hospital Smoking Cessation Service to enable it to effectively deliver its formally documented mandate and role in full.	30/06/2025	05/02/2026	Green	Fully complete (Approved)	04/02/2025	Under-resourced services/teams which may lead to unmet patient/client need.	Funding availability.	Due to the current financial position, it has not been possible to take forward the business case for smoking cessation service investment and development. Work is ongoing, however, to identify other opportunities to develop both services. In the meantime, the Hospital Smoking Cessation Service and Public Health Team (who oversee and deliver the HMQ Community Service) continue to collaborate to strengthen connections between services, ensure patients/clients needs are met and facilitate a smooth transition between hospital and community services. A paper is being drafted for SLT which documents how the services are working together and proposes a package of work to maximise opportunities to support patients and staff who smoke to quit.
Legal Services - ADVISORY	Director of Corporate Governance	18/12/2024	We advise the Health Board to engage with external Solicitors on the NPS framework to ensure that detailed costing/breakdowns are provided and that these are verified against the framework to ensure that the legal services are being priced accordingly.	Corporate Governance - Internal Audit/2024/835/MD4/1	Procurement to review the sample of legal invoices and challenge the costs with framework solicitors	31/03/2025	10/08/2026	Green	Fully complete (Approved)	04/02/2025			26.03.25- Contacted Procurement to sample some Blake Morgan invoices. June 2025 update- Procurement are in the process of setting up a legal contract with Blake Morgan to ensure better value for money when using their services. Will update further once this has progressed. August 2026- a comprehensive review is underway to look at legal spend with non Legal & Risk firms. this work will then inform the challenge to reduce the costs of legal spend across the UHB as tighter grip & control is needed.

Mortuary Refurbishment at University Hospital Wales	Executive Director of Finance	23/01/2025	The review of the Capital Projects Manual should be concluded and approved as soon as possible, and brought into use for all projects delivered by Capital, Estates & Facilities as previously agreed.	Corporate Governance - Internal Audit/2025/948/MD1/1	Agreed. A revised Capital Planning Manual in draft has been developed and is being reviewed internally. Upon completion of internal review, it will be shared with colleagues in NWSSP A&A SSu to comment and advise on any suggested amendments etc. The document will then be updated as necessary prior to it being considered within the UHB governance framework for approval,with the intention to implement from 1st June 2025.	31/05/2025	07/11/2025	Amber	Fully complete (Approved)	04/02/2025			Due to workload and staffing issues with the change in Head of Department the review of the draft manual has been delayed. Internal review will now be completed by the end of 2025.
Capital Systems Management (Framework)	Executive Director of Finance	23/01/2025	Framework Policy - There was no framework policy in place to explain, for example: - What to do in case of contractor failure/ withdrawal. - Extenuating circumstances, such as merging of two individual framework contractors. - Responsibility and accountability for the framework - To ensure ongoing governance is outlined e.g. regular credit checking of contractor and parent companies etc.	Corporate Governance - Internal Audit/2025/729/MD2/1	Partially Completed: The draft Capital Management Plan appropriately references use of the framework. The plan is currently being peer reviewed and will be finalised when approval can be tabled. Policy will be drawn up to outline framework usage protocol, including changes to the framework, and ownership.	30/04/2025	07/11/2025	Amber	Fully complete (Approved)	04/02/2025			Awaiting comments on final draft from Internal Audit.
Capital Systems Management (Framework)	Executive Director of Finance	23/01/2025	Contract rates should recognise inflation as appropriate - Due to inflation and recognition of the time value of money in relation to the length of the framework (4 years + potential 2-year extension). A lesson learnt exercise should be undertaken now that the framework is operating to determine how attractive the framework is to contractors, reviewing uptake rates, whilst also confirming that the framework is operating as intended and continues to offer Value for Money (VfM). The Health Board have advised that they are undertaking a 'post implementation review' to ensure that the framework is successful from both a Health Board and contractor perspective.	Corporate Governance - Internal Audit/2025/729/MD3/1	A lesson learnt exercise will be undertaken to establish whether the framework is operating as expected and fulfils the needs of the Health Board and contractors.	30/05/2025	07/11/2025	Amber	Fully complete (Approved)	04/02/2025			The new framework for contractors is now in place and appropriate changes were made to recognise the potential shortfalls in the initial framework to reduce the risk to the UHB
Capital Systems Management (Framework)	Executive Director of Finance	23/01/2025	Framework contracts should be dated before commencement of the framework - Of the 30 framework contracts sampled, 4 in the largest size lot were undated (though each stated a framework end date). The contract seals were applied in April 2024, shortly after the Framework was launched. Confirmation was received that no works contracts were let with these contractors before the framework contracts were finalised.	Corporate Governance - Internal Audit/2025/729/MD4/1	Completed: The Health Board have re-iterated policy in their new draft Capital Management Plan guidance to ensure that contracts are not undertaken off-framework without following appropriate Health Board procurement policies. Framework contracts will be signed, sealed and dated ahead of framework commencement and works undertaken under that framework for all future frameworks.	20/01/2025	07/11/2025	Amber	Fully complete (Approved)				The improved governance arrangements introduced requires all contracts to be fully completed including dates prior to requisitions being raised on the oracle system
Mortuary Refurbishment at University Hospital Wales	Executive Director of Finance	23/01/2025	The UHB should liaise with the relevant frameworks and obtain assurance that appointed advisers hold (and maintain) appropriate Professional Indemnity Insurance for the period of the contract and thereafter.	Corporate Governance - Internal Audit/2025/948/MD6/1	The UHB will ensure a process is in place with procurement, so on further schemes insurances documents are included from the outset.	31/03/2025	07/11/2025	Amber	Fully complete (Approved)	04/02/2025			Agreed. Head of Capital Planning to ensure that procurement confirm insurance documents are in place before progressing with any award.

Risk Management and Board Assurance Framework 2025	Director of Corporate Governance	02/04/2025	Review of Corporate Risk Register - The Corporate Risk Register is again presented to the Board, but its current format provides little or no assurance that the risks included within it are being effectively managed.	Corporate Governance - Internal Audit/2025/941/MD3/1	Once migrated to the new risk management software, the Corporate Risk Register will be refreshed to ensure that it can be presented to the Board and sub-committees in a meaningful way that provides sufficient assurance that the key corporate risks are being effectively managed.	31/03/2026	22/07/2026	Red	Fully complete (Approved)	20/05/2025			July 26. Reports are being provided to Committees twice a year that includes risk categories within their remit. This is now included as standing item in the forward plan. Quality – Quality and Operational risks P&C – People and Reputational risks F&P – Finance, Commercial and Sustainability risks D&I – Digital, Cyber and Infrastructure risks Audit – Legal and Regulatory risks April 2026 Risk Management & Board Assurance Framework internal audit report noted that this action was still ongoing and provided the following update against this action: 'The reporting of the Corporate Risk Register to the Board remains the same as in the previous year and is not considered to add value in its current format. The Health Board has set a target of fully populating AMaT by the end of March 2026 and then has a further target date of the end of September 2026 for the risks to be moderated which may hopefully lead to a reduction in their overall number. However, it is still considered that there is too large a gap between the strategic risks in the BAF and the operational risk reporting in the CRR'. Action Ongoing - See Finding 4
Risk Management and Board Assurance Framework 2025	Director of Corporate Governance	02/04/2025	AMaT System - The Health Board are currently piloting the risk module within the Medicine Clinical Board. However, as previously highlighted within objective 2 it is taking longer than was anticipated.	Corporate Governance - Internal Audit/2025/941/MD5/1	The Risk Team will work with the Clinical Boards to ensure the risk module within AMaT is implemented as soon as possible.	31/03/2026	22/07/2026	Red	Fully complete (Approved)	20/05/2025			Completed - full transition was achieved by March deadline. April 2026 Risk Management & Board Assurance Framework internal audit report noted that this action was still ongoing and provided the following update against this action: 'Risks have been migrated to AMaT with a deadline for all risks scoring 20 and above of 31 October 2025 and for all other risks to be migrated by 31 March 2026. As at the 10th of March there were approximately 1100 risks already in AMaT with another 400 needing to be transferred. The migration of risks to AMaT has been overseen by a Task and Finish Group which will continue to oversee the moderation of the risks within AMaT by the end of September 2026'. Action Ongoing - See Finding 2
LIMITED - Local Data Repository	Director of Digital and Health Intelligence	17/04/2025	There has been no LDR plan until recently. The current plan does not set out the full scope of the LDR programme including analysis and fully enabling the use of data, together with the resources required to deliver it.	Corporate Governance - Internal Audit/2025/990/MD1/1	Retrospectively promote LDR through the Programme and Projects Gateway process. Employ formal evaluation processes to define the structure, governance, milestones, benefits and artefacts that are expected from the LDR team[s] in delivering a comprehensive solution.	30/06/2025	25/08/2026	Amber	Fully complete (Approved)	22/09/2025		Access to resource is challenging. However, an existing Programme Manager is now stretching across this piece. The timescale for a plan needs to be re-set for cAugust'25 for a meaningful plan.	A programme manager has been assigned, and programme establishment steps (such as a programme brief) are in construction. Alongside this, an LDR Board is being formed (members contacted, ToR in draft). Update 11/09/25 - 1st LDR Board has met (04/09/25). This board agreed ToR and the current status of the programme. It will take several Boards (thus months) for this major programme of works and sub-projects to be re-aligned to individual plans in MSPa (with relevant gateways). The Board have agreed a HLP (High Level Plan) for the LDR however, which offers some sequencing and risk assessment. Update 19/09/2025 - Structure, Governance, Milestones and deliverables are now managed for LDR initiatives via a Programme Board and use of MS Project (MSPa) within D&HI. Finding delivered, status amended to 'Awaiting Approval'.

LIMITED - Local Data Repository	Director of Digital and Health Intelligence	17/04/2025	The LDR programme does not have a defined budget monitoring process, with costs associated with the LDR being held in multiple cost centres. We note that the LDR has received funding from the NDR programme, and these costs are clearly identified, although not as part of the programme overall. Without a defined cost centre and monitoring process the health board may not be able to effectively plan for the LDR and there is a lack of clarity over the costs associated with it.	Corporate Governance - Internal Audit/2025/990/MD2/1	The LDR has a defined budget for staffing costs only, with everything else coming out of the general D&HI budget. Develop a Zero Baseline Budget position analysis against an agreed definition of the scope of LDR. Use the ZBB output to form the basis of a delivery and management budget for LDR.	31/07/2025	25/08/2026	Amber	Fully complete (Approved)	22/09/2025			Finance Management for LDR runs through Leitchan Smith (Technical Lead for LDR, and Nigel Lewis (Finance Management within D&HI). Both will be members of the LDR Board being established in August'25. Finance management of LDR will be scope of that Board. Update 11/09/25 - 1st LDR Board sat on 4th Sept '25. This matter was addressed: "Simon Davies highlighted that one of the audit actions related to budget clarity and asked who would be responsible for overseeing this area. Jackie Miller (Finance Business Partner) was identified as the appropriate contact. SD will follow up with Jackie to clarify current budget processes and explore the possibility of her attending the Programme Board on a quarterly basis to provide financial update." Update 29/09/2025 - LDR spend is now reported into LDR Board via Programme Lead Simon Davies. Status amended to 'Partially complete', as the costs of LDR exist across two cost centres now one, but are gathered for LDR Board review and management. Update Aug 2026 - All costs are now gathered (tagged) from Oracle for LDR and reported to the monthly LDR Board, chaired by Exec Director David Thomas
LIMITED - Local Data Repository	Director of Digital and Health Intelligence	17/04/2025	Due to the link to the NDR there was no scope document, PID or business case developed for the Health Board LDR, with the programme treated as business as usual. With an absence of a formal scope document and exercise there is a lack of clarity over the full needs of the Health Board, and a disconnect between the data architecture aspects and the analysis aspects.	Corporate Governance - Internal Audit/2025/990/MD4/1	The Programme management will act as a bridge between the National Programme and the work carried out within it and our local Programme. Artefacts from the NDR FBC may form a baseline for the scope to be defined in Management Action #1. The Health Board requirements will need to be captured and reviewed alongside the national requirements.	30/06/2025	25/08/2026	Amber	Fully complete (Approved)	20/08/2025			New Programme Manager (part time due to stress on D&HI resources) is tasked to draw together a programme brief and subsequent plan, under the ownership of a newly established programme board. 1st LDR Board held on 4th Sept which established the link between National NDR group and our new organisational governance over LDR (via this LDR Board). The NDR Board member (Dave Price) is a core member of the local (CaV) LDR Board, and relays information and governance positions between.
LIMITED - Follow Up: Alcohol Standards	Executive Director of Public Health	05/06/2025	1.1 - The Senior Leadership Board should be asked to consider if all wards are able to ask alcohol screening questions, and if this is agreed, further screening SOPs would need to be produced for other areas within the Health Board, to meet the needs of each ward (bearing in mind the different populations likely to be present e.g. mental health, maternity, orthopaedic etc). 1.2 - Once the EU screening pilot becomes 'business as usual' for the Health Board, appropriate reporting mechanisms should be established; this may include reporting of key performance indicators to the APB Board. If screening is expanded to other areas of the Health Board, there should be agreement on appropriate reporting mechanisms for these areas.	Corporate Governance - Internal Audit/2025/996/MD1/1	1.1 - Meetings are ongoing between relevant stakeholders (including the EU Team, APB Support Team, Public Health Team and CAVDAS) to support continued alcohol screening in the EU over the longer-term. This includes development of strengthened operating processes, governance, and data collection and analysis to underpin it. Once permanent processes and governance for alcohol screening in the EU are established, the work will form part of the 'business as usual' contract management meetings for CAVDAS. If screening for alcohol is extended to cover other areas of the Health Board, the EU screening pilot SOP could provide a template for the development of other SOPs that are tailored to specific departments and teams (screening process, referral points, information given and data collection should remain the same).	31/08/2025	02/02/2026	Red	Fully complete (Approved)				Update August 2025: There have been a number of completed meetings between relevant stakeholders to support continued alcohol screening in the EU over the longer-term. Following the evaluation into the EU Alcohol Screening Project, an action plan was developed. A Steering Group has been established to ensure strengthened operating processes, governance, and data collection of the EU Screening Project. The group will meet for the first time on the 18th August 2025. At this meeting, progress against the action plan will be reviewed and further actions developed where necessary, with the aim of establishing the long-term sustainability of the project. There are ongoing discussions between CAVDAS and the APB Support Team regarding closer alignment of CAVDAS objectives and the NHS, including on the EU Alcohol Screening Project becoming part of 'business as usual'. A Health Board Alcohol Harm Prevention Group has also now been established (see below for more details). This will meet for the first time in September 2025. One of the areas for discussion in this group will be wider alcohol screening in other areas of the Health Board. As outlined in the audit action (above), if screening for alcohol is extended to cover other areas of the Health Board in the

LIMITED - Follow Up: Alcohol Standards	Executive Director of Public Health	05/06/2025	1.1 - The Senior Leadership Board should be asked to consider if all wards are able to ask alcohol screening questions, and if this is agreed, further screening SOPs would need to be produced for other areas within the Health Board, to meet the needs of each ward (bearing in mind the different populations likely to be present e.g. mental health, maternity, orthopaedic etc). 1.2 - Once the EU screening pilot becomes 'business as usual' for the Health Board, appropriate reporting mechanisms should be established; this may include reporting of key performance indicators to the APB Board. If screening is expanded to other areas of the Health Board, there should be agreement on appropriate reporting mechanisms for these areas.	Corporate Governance - Internal Audit/2025/996/MD1/2	1.2 - Following the development of governance structures to underpin longer-term screening in the EU, a system will be developed for regular monitoring of screening in the EU and for reporting to senior managers on a quarterly basis. The need for greater collaborative working on alcohol will be discussed at an upcoming Senior Leadership Board meeting (May 2025). At that meeting, the development of a quarterly meeting on alcohol prevention ('Alcohol Prevention Group'), with representation from all relevant Clinical Boards, will be proposed by the Executive Director of Public Health. If this is agreed, there can be ongoing discussion on how work on alcohol prevention can develop across the Health Board over the coming years. This would include work to consider wider screening for alcohol beyond the EU and how and where data on this would be recorded, analysed and reported, informed by the EU screening pilot.	30/09/2025	02/02/2026	Red	Fully complete (Approved)				Update August 2025: A proposed contract monitoring specification for the EU Alcohol Screening Project has been developed by the APB Support Team and will be agreed with partners at the first EU Alcohol Screening Project Steering Group meeting (see above). Overall processes for regular monitoring and reporting of screening in the EU will also be agreed through this group. The Public Health Team presented an update on the EU Alcohol Screening Project at Senior Leadership Team Meeting on 15th May 2025. This presentation also highlighted the need for greater collaborative working on alcohol. During this meeting, SLT approved the development of a quarterly Health Board Alcohol Harm Prevention Group and, subsequently, all Clinical Boards were asked to nominate a representative to attend this meeting. The first of these meetings will take place on 25th September 2025. The group will aim to provide colleagues from across the organisation the opportunity to understand what work is happening on alcohol across the Health Board and to collaborate on any existing and new alcohol harm prevention work. Once established, this group can also consider wider screening for alcohol beyond the EU, including the recording, analysis and reporting of data from any potential future wider
LIMITED - Follow Up: Alcohol Standards	Executive Director of Public Health	05/06/2025	The Health Board should adopt a validated screening tool across the Health Board to maintain consistency.	Corporate Governance - Internal Audit/2025/996/MD2/1	The alcohol screening pilot has been extended in the EU over a temporary period, with funding to support this provided by the APB. There are currently ongoing meetings (see above) to develop its longer-term operating model, governance and reporting structures. As outlined above, the development of a quarterly Health Board-wide meeting on alcohol prevention will support collaborative work on implementation of alcohol screening in other areas of the Health Board.	31/01/2026	02/02/2026	Amber	Fully complete (Approved)				Update August 2025: As outlined in the comments on other audit actions, there have been a number of meetings that have taken place to strengthen and develop the longer-term operating model, governance and reporting structures for the EU Screening Project. As outlined in the comments on other audit actions, the development of a quarterly Health Board-wide meeting on alcohol harm prevention will support collaborative working on alcohol, including consideration of wider implementation of alcohol screening in other areas of the Health Board. The first of these meetings is scheduled for September 25th 2025, with colleagues from across different departments in the Health Board invited. Update 06/10/25: EU Alcohol Screening Project Development Meeting planned for 20th October 2025 to finalise KPIs and monitoring of the project. Presentation of the work at the Safeguarding Steering Group Meeting held on the 30th September 2025. Formal governance processes now through that meeting with updates to be provided to them on a quarterly basis.
LIMITED - Follow Up: Alcohol Standards	Executive Director of Public Health	05/06/2025	Following completion of the ABI training by PHW, the Health Board should ensure that all relevant staff are made aware of the training and complete it as required. Records should also be maintained to confirm completion of the training by required staff.	Corporate Governance - Internal Audit/2025/996/MD3/1	Once ABI training is made available by PHW, this will be promoted throughout the Health Board to all staff, for example using screen savers, and in the newsletter. Staff and their line managers will need to ensure competency of staff as per all other duties fulfilled.	30/11/2025	02/02/2026	Amber	Fully complete (Approved)				Update August 2025: We have been informed that Public Health Wales are currently undertaking final amendments on the ABI e-learning module and it should be launched soon (no date confirmed). Once this is released, the Public Health Team can then work with Communications Team colleagues to promote the module via communications to staff groups. Update December 2025: The Public Health Wales MECC training has now been made available and the Public Health Team are now working with the Communications Team to ensure promotion of this. This has already been highlighted through the Public Health Newsletter and directly to members of the Alcohol Harm Prevention Group Meeting. Further ways to promote this are now being explored.

M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Deployment Plan - There is no deployment plan or structured plan to work with departments to enable them to understand the capabilities of M365, including Copilot and identify cases for use and so increase uptake. We also note that the M365 Programme Lead stated that there is a lack of awareness of the platforms capabilities and strategic value which may also impact on the ability of the health board to gain full value, together with a lack of awareness and understanding about the platforms limits within the broader organisation which feed into additional requests for support.	Corporate Governance - Internal Audit/2025/1036/MD1/1	1. Development of a Deployment and Awareness Plan - We will develop an appropriate deployment plan that aligns with departmental needs and focuses on M365's full range of capabilities, including Copilot. This plan will incorporate training sessions, and internal communications, to ensure that staff are equipped to effectively use the platform. The focus of the plan will be to target the portion of M365 that delivers high value to the Health Board and not aim at covering everything within M365. Online generic and bespoke training material can be developed to demonstrate real-life use cases, highlighting the strategic value M365 can bring to their daily operations. The plan will include clear messaging on the platform's benefits and how it can improve productivity and collaboration, aiming to drive higher engagement and adoption.The M365 team will not be the only resource for this initiative.	26/09/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - M365 tools in use within CaV are by dictate of the National tenancy. The exception being the use of Viva Engage) at the request of the uHB Communications Dept in late 2024. All 'new' products in the M365 suite that are requested to be rolled into LIVE operational usage will be agreed by the M365 Steering Group, and communicated to Executives via David Thomas as 'M365 Exec Link'. This offers assurance that a governed programme of implementations is now in place. It should be noted that the 'core' M365 Team resource has been dropped to 2 staff (from 3) as of the conclusion of the OCP process in September 2025. This diminishes the volume of resource to co-ordinate M365 activities. M365 has also been re-sat within the Digital Operations team of D&HI, falling under Mr. Joseph Pike from 22/09/2025. These audit actions are remaining with Mark Cahalane, in the absence of Leigh Richardson whose post has been lost to the uHB via the OCP process.
M365 Benefits Realisation	irector of Digital and Health Intelligence	26/06/2025	Deployment Plan - There is no deployment plan or structured plan to work with departments to enable them to understand the capabilities of M365, including Copilot and identify cases for use and so increase uptake. We also note that the M365 Programme Lead stated that there is a lack of awareness of the platforms capabilities and strategic value which may also impact on the ability of the health board to gain full value, together with a lack of awareness and understanding about the platforms limits within the broader organisation which feed into additional requests for support.	Corporate Governance - Internal Audit/2025/1036/MD1/2	2. Utilisation of the Established Steering Group, Including Updated Terms of Reference - We will utilise the established steering group to provide oversight and drive the successful adoption of M365 across departments. The group's Terms of Reference (ToR) will be updated to include responsibility for tracking and assurance of benefits. The Steering Group will identify departmental champions, who will be responsible for providing key value areas within their departments. This information will guide the deliverables of the deployment plan. Regular steering group meetings will continue to be held and will be used to assess progress, address any challenges, and ensure the plan remains on track. Furthermore, as part of the plan we can engage with the Clinical Boards at their management team meetings and ascertain their M365 requirements and areas they will benefit from. E.g SharePoint, Teams training and such like.	01/08/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - Steering Group has been made aware of the Audit and accepts its findings. Departmental champions have been extended to include the two missing areas (Medicine and Acute Child Health). The group continues to function valuably sharing best practice and implementation approaches. It should be noted that the 'core' M365 Team resource has been dropped to 2 staff (from 3) as of the conclusion of the OCP process in September 2025. This diminishes the volume of resource to co-ordinate M365 activities. M365 has also been re-sat within the Digital Operations team of D&HI, falling under Mr. Joseph Pike from 22/09/2025. These audit actions are remaining with Mark Cahalane, in the absence of Leigh Richardson whose post has been lost to the uHB via the OCP process.
M365 Benefits Realisation	21/08/2024	26/06/2025	Deployment Plan - There is no deployment plan or structured plan to work with departments to enable them to understand the capabilities of M365, including Copilot and identify cases for use and so increase uptake. We also note that the M365 Programme Lead stated that there is a lack of awareness of the platforms capabilities and strategic value which may also impact on the ability of the health board to gain full value, together with a lack of awareness and understanding about the platforms limits within the broader organisation which feed into additional requests for support.	Corporate Governance - Internal Audit/2025/1036/MD1/3	3. Clear Communication on Platform Limits and Resource Constraints - Develop a detailed Communication Plan aimed at effectively informing the Health Board about existing resources and updates. Clearly state resource limitations and highlight the importance of documentation and training materials. Take the focus from the Steering Group champions and drive towards the value-add areas that they will identify.	26/09/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - M365 Team Resource is communicated via the M365 STeering Group monthly. The group take a view on the value of deployments, and share knowledge and expertise in the uHB gaining greatest value from its investment in M365. It should be noted that the 'core' M365 Team resource has been dropped to 2 staff (from 3) as of the conclusion of the OCP process in September 2025. This diminishes the volume of resource to co-ordinate M365 activities. M365 has also been re-sat within the Digital Operations team of D&HI, falling under Mr. Joseph Pike from 22/09/2025. These audit actions are remaining with Mark Cahalane, in the absence of Leigh Richardson whose post has been lost to the uHB via the OCP process.
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Deployment Plan - There is no deployment plan or structured plan to work with departments to enable them to understand the capabilities of M365, including Copilot and identify cases for use and so increase uptake. We also note that the M365 Programme Lead stated that there is a lack of awareness of the platforms capabilities and strategic value which may also impact on the ability of the health board to gain full value, together with a lack of awareness and understanding about the platforms limits within the broader organisation which feed into additional requests for support.	Corporate Governance - Internal Audit/2025/1036/MD1/4	4. By implementing these actions, we aim to increase the health board's understanding of M365's capabilities, drive adoption, and ultimately enhance the effectiveness and efficiency of the platform across the Health Board. Some work will also need to be conducted to establish Key Performance Indicators (KPIs) as these have yet to be clearly identified. Then approved by newly established Governance Group.	26/09/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - This is a prompt to establish and maintain the function of the M365 steering Group, which is in place and managed. There is no clear (other) action here, and so i am completing this item.

M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Roles and Responsibilities - The role, responsibilities and boundaries of the M365 team are not formally set out. We were informed that the team was originally intended to be 7 people, however only 3 are in place and so resource is constrained. The M365 Programme Manager noted that the aim of the team is to manage the configuration and back end of M365, and also takes on the responsibility of user support and education. However the team is expected to manage any issue related to M365 and have been asked to undertake additional tasks such as troubleshooting applications, providing guidance on use and aiding in developments. The M365 programme lead noted challenges with the current project, including the resource required for licence confirmation, the movers and leavers process and related impact on the licence pool cost and the siloed nature of the organisation.	Corporate Governance - Internal Audit/2025/1036/MD2/1	1. Introduction of the M365 Framework to Define Roles and Responsibilities - We will introduce the M365 Framework, which will start to outline the responsibilities of the M365 Platform and its components across the M365 team and the relevant Digital Teams within the health board. This framework will help delineate the scope of support and services provided, ensuring that responsibilities are clearly defined and understood, reducing the pressure on the M365 team by clarifying which tasks fall under their remit and which should be managed by other teams. For example, the framework will include specific responsibilities for license management and the JML process, ensuring these responsibilities are assigned to the appropriate Digital Teams to reduce unnecessary costs and streamline coordination. Use the Audit findings as a method to drive and initiate the M365 Framework workshop into Digital.	01/08/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - All responsibilities for M365 within D&HI now sit with the Digital Operations team. As such a 'framework' to clarify the roles and responsibilities across Digital Ops and the M365 team is now unnecessary, as the M365 team are a component part of Digital operations. This action can therefore be close/Completed. The 'core' M365 Team resource has been dropped to 2 staff (from 3) as of the conclusion of the OCP process in September 2025. This diminishes the volume of resource to co-ordinate M365 activities. M365 has also been re-sat within the Digital Operations team of D&HI, falling under Mr. Joseph Pike from 22/09/2025. These audit actions are remaining with Mark Cahalane, in the absence of Leigh Richardson whose post has been lost to the uHB via the OCP process.
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Roles and Responsibilities - The role, responsibilities and boundaries of the M365 team are not formally set out. We were informed that the team was originally intended to be 7 people, however only 3 are in place and so resource is constrained. The M365 Programme Manager noted that the aim of the team is to manage the configuration and back end of M365, and also takes on the responsibility of user support and education. However the team is expected to manage any issue related to M365 and have been asked to undertake additional tasks such as troubleshooting applications, providing guidance on use and aiding in developments. The M365 programme lead noted challenges with the current project, including the resource required for licence confirmation, the movers and leavers process and related impact on the licence pool cost and the siloed nature of the organisation.	Corporate Governance - Internal Audit/2025/1036/MD2/2	2. Resource Assessment and Streamlining Responsibilities - Given the current resource constraints, we will conduct an assessment to evaluate the staffing needs of the M365 team to ensure it can effectively manage core responsibilities such as backend configuration, user education, and support. Additionally, we will streamline the team's tasks, focusing on key areas to prevent overburdening the team with noncore activities, such as troubleshooting applications and providing extensive development support, which will be redirected to appropriate teams within the Digital function.	01/08/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - An OCP was conducted against the M365 team in summer 2025. The re-shaped team now exist within Digital Operations, and are supported by the larger technical resources of that overall resource (c50 staff deep under Russell Kent)
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Roles and Responsibilities - The role, responsibilities and boundaries of the M365 team are not formally set out. We were informed that the team was originally intended to be 7 people, however only 3 are in place and so resource is constrained. The M365 Programme Manager noted that the aim of the team is to manage the configuration and back end of M365, and also takes on the responsibility of user support and education. However the team is expected to manage any issue related to M365 and have been asked to undertake additional tasks such as troubleshooting applications, providing guidance on use and aiding in developments. The M365 programme lead noted challenges with the current project, including the resource required for licence confirmation, the movers and leavers process and related impact on the licence pool cost and the siloed nature of the organisation.	Corporate Governance - Internal Audit/2025/1036/MD2/3	3. 'OD and T' Training Functions - Another initiative to ensure a lower requirement of assistance from the Digital Teams in terms of support and usage of the platform is to consider M365 PaaS as a Core Competency required by all staff. As such the OD and T training function of the Health Board should be engaged and asked to provide core training for all staff.	01/08/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - This OD&T team are a part of the M365 Steering Group and guide the provision of centralised 'M365 training' via the M365 site
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Help Desk - Help desk support for staff is available, with all requests going via the helpdesk. We note that the M365 team provided training to helpdesk staff to better enable them to understand how to assign tickets to the correct group, however in many cases calls for 365 are assigned to the 365 team even if another group is better placed for help.	Corporate Governance - Internal Audit/2025/1036/MD3/1	The M365 Framework should account for the mitigations required to address this point. See above.	01/08/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - This isn't an action in itself, and relates to the restcructure of the M365 team undertaken via the Summer 2025 OCP. Now complete

M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Guardrails - Guidance and governance over the use of M365 applications, including for the use of Co-Pilot or other AI tools is largely absent. We also note that the use of controlled environments for the power platform is not enforced which may result in a lack of control and the creation of 'clinical systems' creating clinical, IG and cyber risks.	Corporate Governance - Internal Audit/2025/1036/MD4/1	1. TrustMarque Consultancy Engagement - TrustMarque has been commissioned to provide consultancy services focused on establishing governance for key elements of the M365 Platform as a Service (PaaS), including Co-Pilot, AI, and the Power Platform. Progress so far includes identifying key owners, and the consultancy work is expected to conclude by the end of July 2025. Once complete, the outputs from this engagement will directly inform the M365 Standard Operating Procedures (SOP), supporting the clear assignment of roles and responsibilities within the Digital Teams. This process will ensure that each M365 component is guided and governed by the appropriate subject matter experts. Additionally, it will set out best practices for utilising M365 tools and establish policies regarding the use of controlled environments for the Power Platform, helping to guarantee compliance with regulatory, information governance (IG), and cybersecurity requirements.	31/08/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			Update 29/09/2025 - Trustmarque and the uHB are underway on a series of these guardrails. This will start with Power BI in November'25. Update 07/01/2026 - These are the GUARDRAILS that D&HI are leading on the production of across tools (BI, Co-Pilot, Apps. Automate etc...). The current resource plan is to publish these during Q1 and Q2 2026. The guardrails and attributable considerations will lead to resource call for bolstered D&HI resources to support the value realisation of M365 tools across 17,000 staff. These resource requests will be made to corporate groups within 2026. Update July 2026 - Guardrails now in place for Co-Pilot and BI, through Trustmarque consultancy support
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Guardrails - Guidance and governance over the use of M365 applications, including for the use of Co-Pilot or other AI tools is largely absent. We also note that the use of controlled environments for the power platform is not enforced which may result in a lack of control and the creation of 'clinical systems' creating clinical, IG and cyber risks.	Corporate Governance - Internal Audit/2025/1036/MD4/2	2. Governance Group around implementing the M365 - To support the successful implementation and ongoing optimisation of the Microsoft 365 (M365) platform, it is essential to establish a formal Governance Group that reports directly to the Digital & Infrastructure Committee and Directors of Digital Peers. This group will provide the necessary oversight, strategic direction, and accountability to ensure that the deployment of M365 aligns with organisational priorities, information governance standards, and digital transformation goals. It will also serve as a central forum for decision-making, risk management, and the coordination of resources, helping to maximise the value of the platform while ensuring compliance and user adoption across the Health Board.	31/10/2025	25/08/2026	Amber	Fully complete (Approved)	02/09/2025			M365 Steering Group existent since Oct'24. Action complete.
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Benefits Tracking - There is no benefits plan or tracker developed solely for delivery of benefits within the Health Board. We also note that there are no defined success metrics for measuring successful roll out such as user adoption rates or productivity improvements.	Corporate Governance - Internal Audit/2025/1036/MD5/2	2. Tracking and Monitoring through the M365 Steering Group - The newly established M365 Steering Group will be key in tracking the realisation of benefits. Furthermore, through the Steering Group M365 Champions, we will identify value add areas within each clinical board and use these areas as metrics to demonstrate benefits realisations. We will update the group's Terms of Reference (ToR) to include specific accountability for monitoring progress against the benefits plan, reviewing success metrics, and ensuring actions are taken to realise value.	31/10/2025	25/08/2026	Red	Fully complete (Approved)	02/09/2025			M365 Programme Team no longer exists, due to financial constraints. The M365 Steering Group has been brought into existence since Oct'24
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Benefits Tracking - There is no benefits plan or tracker developed solely for delivery of benefits within the Health Board. We also note that there are no defined success metrics for measuring successful roll out such as user adoption rates or productivity improvements.	Corporate Governance - Internal Audit/2025/1036/MD5/3	3. Integration of Success Metrics into Governance and Reporting - We will integrate the benefits tracking and success metrics into the existing governance structure, suggesting that we establish reporting regularly into the Digital & Infrastructure Committee and Directors of Digital Peer group. This ensures continuous oversight of M365's effectiveness, with clear updates on user adoption, system engagement, and productivity improvements.	31/10/2025	25/08/2026	Red	Fully complete (Approved)	02/09/2025			Metrics of usage by CB are now available to M365 champions/CBs. These are reviewed by the M365 Steering Group.
M365 Benefits Realisation	Director of Digital and Health Intelligence	26/06/2025	Benefits Tracking - There is no benefits plan or tracker developed solely for delivery of benefits within the Health Board. We also note that there are no defined success metrics for measuring successful roll out such as user adoption rates or productivity improvements.	Corporate Governance - Internal Audit/2025/1036/MD5/4	4. Case Studies - In a similar manner to other Health Boards in England (Link), we can write Case Studies demonstrating the benefits realised within CaV Initially, starting out by reaching out to identified Health Boards that have already authored some case studies.	28/11/2025	25/08/2026	Red	Fully complete (Approved)	02/09/2025			This is a duplicate Audit finding for M365. Closing.

Deprivation of Liberties Safeguards (DoLS)	Executive Nurse Director	10/09/2025	The Health Board does not have a Standard Operating Procedure on DoLS - The Health Board has several documents describing the DoLS process including guides and training materials. Whilst useful, these documents do not describe the full end-to-end procedure and associated target timelines. However, it was recognised in the Mental Capacity Act (MCA) Team's formal DoLS Work Plan Tracker 2025/26 that a formal procedure document is to be produced, and this will commence in August 2025. The aforementioned previous audits also identified that the two Health Boards have documented DoLS procedures in place.	Corporate Governance - Internal Audit/2025/1023/MD2/1	A DoLS procedure document will be produced to illustrate and explain the full end-to-end procedure for DoLS to provide staff with a clear overall view.	31/03/2026	05/08/2026	Amber	Fully complete (Approved)	18/11/2025			
Deprivation of Liberties Safeguards (DoLS)	Executive Nurse Director	10/09/2025	DoLS training is not mandatory - DoLS training is not mandatory for staff in the Health Board. Instead, training is optional, and completion is left to the discretion of individual staff members and their ward managers. This has resulted in a low number of staff being trained on DoLS and this was substantiated by our ward visits whereby one ward had only one trained staff member. Ward Managers highlighted that DoLS training can be challenging to manage as it is not recorded on ESR. In two of the three wards visited, ward managers could not confirm the number of staff trained. We reviewed DoLS training in two other Health Boards and found that DoLS training was mandatory for ward staff in both.	Corporate Governance - Internal Audit/2025/1023/MD3/1	A training strategy will be developed that considers how DoLS training should be implemented across the UHB within available resource. This will consider different approaches such as: the use of a staged approach to target key staff i.e. ward managers and deputy ward managers (with dissemination of learning through clinical teams), hybrid training, support from ECOD. A scoping exercise will be undertaken to identify what has worked well in other organisations.	31/03/2026	05/08/2026	Amber	Fully complete (Approved)	18/11/2025			Scoping exercise carried out across other UHBs in Wales and identified that level of training that is mandated in CAVUHB is the same as that in other areas. DoLS is included in the All Wales MCA Level 1 and 2 mandatory training and available to staff via ESR, relevant codes are 000 NHS Wales - MCA Level 1 and 000 NHS Wales - MCA Level 2. Further 'DoLS in Practice' training is also available in CAVUHB, to build upon the mandatory requirements. This provides support around the practical application of the safeguards and is available to all staff as a face to face teaching every month.
Standards of Business Conduct	Director of Corporate Governance	17/12/2025	Declaration Rates of Staff - The Declaration of Interest and combined gifts, hospitality, and sponsorship register exists and is reported annually to the Audit and Assurance Committee. However, there is low compliance of declarations and there is limited follow-up which reduces assurance. Whilst we note that there is no formal compliance target, as of the 1st of May 2025, the total ESR returns factoring in staff head count was 25% while 2024 was 19.5%. This demonstrates the growth in the volume of declarations received, however, 75% are not making any form of declaration. The target group of Band 7 and above equates to a return rate of 41%.	Corporate Governance - Internal Audit/2025/1057/MD2/1	Management will ensure Clinical Board accountability by using declaration compliance data to monitor trends and identify areas of low compliance for target group of Band 7 and above within the Clinical Board performance meetings. They will follow up on compliance gaps with targeted improvement actions.	31/12/2026	22/07/2026	Amber	Fully complete (Approved)	03/02/2026			Data has been shared into CB Reviews on request from Operations.
Financial Sustainability - Temporary Staffing Controls	Executive Director of Finance / Executive Director of People and Culture	22/12/2025	PMO Value Proposition – Medical and Dental workforce - The Project Management Office (PMO) was introduced in January 2025 to enhance scrutiny over temporary staffing requests. It was intended to complement the shift of approval responsibility from directorates to Clinical Board senior leadership, creating a dual-layered governance model. However, following a review of temporary staffing expenditure data before and after the PMO's inception, there is no clear evidence of financial impact attributable to the PMO for the medical and dental workforce. However, the Health Board did see an impact of the Nursing Hub will successfully saw a reduction in overtime which was replace by Bank staff. Analysis of the Medical and Dental Bank & Agency Dashboards shows that: • Pre-PMO (Sept–Dec 2024): Monthly temporary staffing spend for medical workforce ranged from £1.23M to £1.45M, totalling £5.55M over four months. • Post-PMO (Jan–Aug 2025): Monthly spend remained broadly consistent, ranging from £1.08M to £1.41M, totalling £10.36M over eight months.	Corporate Governance - Internal Audit/2025/1018/MD3/1	• A decision was made by the Medical Director to remove the dual tier approval process for medical and dental bank shift requests – instead the approval process has been handed back to the Clinical Board Directors. • Medical agency requests are still considered by the Executives on a weekly basis.	22/12/2025	06/01/2026	Amber	Fully complete (Approved)				This action has been marked as complete by Internal Audit in the issue of the final report on 22/12/2025.

LIMITED - Clinical Board Adherence to the Managing Attendance at Work Policy	Executive Director of People and Culture	05/03/2026	Guidance on recording an absence - The Managing Attendance at Work Policy is supported by a range of procedural guides and supplementary guidance available to managers via the Health Board's SharePoint site. However, specific guidance on how to record sickness absences within ESR and Health Roster are not included within the digital "Managing Attendance" training module. Instead, these are held as separate documents on ESR (ESR User Manual – Recording a Sickness Absence) and SharePoint (Add an Unavailability to Roster). This fragmentation has resulted in uncertainty among Ward Managers regarding the correct process for recording absences. As a result of this ambiguity, testing identified eight cases where single episodes of sickness absence were incorrectly recorded as multiple instances. In these cases, managers aligned the absence periods to dates shown on self-certifications and/or fit notes rather than recording the full absence period from the first to the last day. This resulted in the eight episodes being recorded as 21 separate instances and, in six cases, created gaps totalling 20 days of unrecorded sickness absence.	Corporate Governance - Internal Audit/2026/1053/MD1/1	ESR and Health Roster guidance on how to record an absence will be consolidated within the Managing Attendance training to ensure all managers are trained in this aspect of the process.	31/03/2026	27/03/2026	Red	Fully complete (Approved)	19/05/2026			A link to the guidance on how to record an absence is now available within the Managing Attendance online toolkit. Slides have also been incorporated into the MAAW training to ensure all managers are trained in this aspect of the process.
LIMITED - Clinical Board Adherence to the Managing Attendance at Work Policy	Executive Director of People and Culture	05/03/2026	Missing or unrecorded documentation - Review of 64 sickness absence records identified weaknesses in the retention and recording of supporting documentation. Of the total sample, 20 records (31%) were not supported by either a fit note or self-certification. In the absence of appropriate documentation, assurance cannot be obtained that sickness absence has been appropriately justified or managed in accordance with policy requirements. The policy states that "for any period of sickness absence between 1-7 calendar days an employee must complete a self-certification form unless already certified by a Fit Note or hospital certificate. Employees must submit doctors Fit Notes certificates for sickness from the 8th calendar day of sickness absence onwards." In addition, systems administrators confirmed that while Health Roster includes functionality to record receipt of self-certifications, this field is not mandatory when creating a sickness record and is therefore used inconsistently. This increases the risk that required documentation is not obtained, recorded, or retained, and contributes to reduced data quality and incomplete sickness absence records within ESR.	Corporate Governance - Internal Audit/2026/1053/MD2/1	Management will ensure that ward managers comply with the requirement under the policy to ensure all absences are supported with appropriate documentation. This will be highlighted as part of the MAAW training. We will discuss with Allocate Healthroster team about making mandatory system fields designed to capture self-certification/fit notes. This will be limited only to the field "Self-certification/Fit note received: Y/N" and the associated "date of certification" field.	31/03/2026	31/03/2026	Red	Fully complete (Approved)	19/05/2026			Managing Attendance at Work Policy updated to include the management requirement to ensure all absences are supported with appropriate documentation, self-certification/fit notes. Discussed with UHB Healthroster team about making mandatory system fields designed to capture self-certification/fit notes. Healthroster team taking this forward with Allocate.
LIMITED - Clinical Board Adherence to the Managing Attendance at Work Policy	Executive Director of People and Culture	05/03/2026	Unactioned Review prompts - Excluding absences that should have triggered review prompts but were mitigated by management discretion, there were 13 absences where a review prompt was triggered. Of these, three (19%) had been addressed. These can be summarised as follows: • Seven informal discussion review prompts triggered – Two (20%) were actioned; and • Six Formal meeting review prompts triggered – One (17%) was actioned. Of the five formal review prompts that had not been actioned: • Two should have been at the first formal meeting stage; • Two should have been at the second formal meeting stage; and • One should have been at the final meeting stage. In all cases above, Ward Managers were unable to provide a reasonable justification for failure to host the required meetings or to move staff appropriately through the review stages required by the policy.	Corporate Governance - Internal Audit/2026/1053/MD3/1	Regular People Services reviews in 'hot spot' areas to monitor compliance or review prompts noting 'managers discretion' part of the Managing Attendance at Work Policy. Ensure conversations and reasons are appropriately recorded where progression through the Policy is not applied. Communication to the Clinical Board Triumvirates around monitoring and expectations.	30/04/2026	14/05/2026	Green	Fully complete (Approved)	19/05/2026			The People Services Team have set up monthly meetings in hotspot areas across all Clinical Boards. The team also pull monthly reports on the top STS sickness cases across the UHB and review what stage these cases are at in line with the Managing Attendance at Work (MAAW) Policy. The team have also scheduled audits in hotspot areas. Themes will be identified, and targeted interventions and support will be put in place to address the findings.

LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Awareness of the Recovery of Overpayments Procedure - The Procedure confirms that Line managers must promptly inform the Payroll Service of any pay changes. Timely and accurate notifications are essential to prevent payroll errors, so all staff should be familiar with this policy. We were advised by the Head of people Assurance and Experience that there had been no formal communication regarding the implementation of this procedure, we developed a survey to assess managers' comprehension of staff changes, terminations, and absences to ensure that they are being processed in a timely manner. We received 17 out of 43 survey responses, resulting in a response rate of 40%. Additionally, two individuals replied via email indicating that they were not involved in staff changes and therefore felt unable to complete the survey. The survey requested participant awareness of the 'All Wales Recovery of Overpayments' Procedure, how they accessed it, and how this information was shared with them. Of the respondents, nine (53%) were not aware of the policy, while eight (47%) were aware, mainly as it was communicated via email.	Corporate Governance - Internal Audit/2026/1056/MD1/1	Awareness campaigns and targeted communications will be launched to enhance employee's awareness of the 'All Wales Recovery of Overpayments' Procedure and how to access it. This could include the People Services Team undertaking virtual awareness training sessions across the UHB.	31/07/2026	07/08/2026	Green	Fully complete (Approved)	19/05/2026			Awareness campaigns and targeted communications have been launched to enhance employee's awareness of the 'All Wales Recovery of Overpayments' Procedure and how to access it. Targeted communications including directly to the Clinical Boards, Loop, ESR messages and screensavers etc. The People Services Team undertaking virtual awareness training sessions across the UHB on a monthly basis.
LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Review of Induction and Exit Processes for New Managers - Section 9 of the Procedure addresses Training and Awareness. It specifies that NHS organisations are required to inform all employees, workers, and managers of the Procedure upon commencement of their roles. Additionally, the Procedure should be accessible via the NHS organisation's SharePoint site and referenced in induction programs and new manager training sessions. During the audit, Health Board contacts could not confirm whether the 'All Wales Recovery of Overpayments Procedure' or the SMA app is included in induction training for new managers. However, we were able to review the Workforce toolkits provided for induction. The Workforce Induction Toolkits provided to new managers currently do not include the Procedure. Additionally, there is no reference to the SMA app within these materials. This omission may result in new managers being unaware of key procedures and digital tools relevant to their roles. The Leavers Checklist offers a link to the SMA app	Corporate Governance - Internal Audit/2026/1056/MD2/1	The Induction process and toolkits will be reviewed and updated to ensure that a) all new starters are aware of the need to identify any pay impacting changes to their line manager in a timely manner, to ensure that overpayments do not occur, and b) newly appointed managers are clear of their role in the timely processing of information via the SMA app and associated payroll deadlines. Management will review the Leavers Checklist to ensure that overpayments are explicitly addressed and will strengthen communication and guidance to supervisors to improve awareness and usage of the checklist.	31/07/2026	11/08/2026	Green	Fully complete (Approved)	19/05/2026			Aug 2026 - The Induction process and toolkits have been updated to ensure that a) all new starters are aware of the need to identify any pay impacting changes to their line manager in a timely manner, to ensure that overpayments do not occur, and b) newly appointed managers are clear of their role in the timely processing of information via the SMA app and associated payroll deadlines. The Leavers Checklist has also been updated to ensure that overpayments are explicitly and guidance to supervisors is provided to improve awareness and usage of the checklist.
Risk Management and Board Assurance Framework	Director of Corporate Governance	20/04/2026	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.	Corporate Governance - Internal Audit/2026/1104/MD1/1	The errors noted in the Risk Management Policy have been corrected and the supporting documentation updated to reflect current practice.	20/04/2026	23/04/2026	Amber	Fully complete (Approved)	19/05/2026			April 2026 - action marked as complete in the final IA report issued. The updated Risk Management Policy (UHB 023) was approved by the Audit & Assurance Committee on 03/02/2026.
Wellbeing Hub at Park View	Executive Director of Finance	01/05/2026	Project Team Monitoring - Whilst the Project Team terms of reference required monitoring against a Management Control Plan, this was not evidenced in practice. Whilst the Flash reports included dates of key activities, for both "planned" and "revised" completion dates, the planned dates were not the original dates and so did not give a sense of overall progress and slippage. In totality the reporting received by the Project Team did not present a sufficiently clear picture of project delivery, or of individual workstream delivery against agreed actions (see also Key Finding 4). Whilst acknowledging management's assurance that original dates are included within wider progress reporting, for improved clarity they could be incorporated into the Flash reports.	Corporate Governance - Internal Audit/2026/1186/MD2/1	Health Board Highlight reports updated post-audit fieldwork and now addresses these findings.	01/05/2026	06/05/2026	Amber	Fully complete (Approved)	19/05/2026			IA report comment on final report 01/05/2026: N/A Actioned Since Audit Fieldwork. Action subsequently marked as complete.

Medicines Management	Executive Medical Director	24/06/2026	Completion of three yearly medicines management training - We were provided with the following data from ESR for the refresher training for the sample wards: For Ward B4 at UHW, 27% of staff completed their confirmation / update training more than three years ago. Across the other wards sampled, only a very small number of staff had completed the refresher training and all of those had completed it over three years ago.	Corporate Governance - Internal Audit/2026/1124/MD1/1	We will review how frequently Medicines Management training should be delivered within the All-Wales Nurse Advisors for Medicines Management Group.	31/07/2026	27/07/2026	Red	Fully complete (Approved)	01/09/2026			We have met with the All Wales Medication Management group to discuss the frequency of Medication Management training. All other Health boards in Wales are in the same position where MARS e-learning is mandatory every 3 years for staff administering medications, but it is not mandated on ESR, therefore staff are not reminded to complete. Practice Development Nurse are aware of this and are able to support in reminding staff to complete the training. This information is also included in the initial Medication Management training where staff are reminded it is their professional responsibility to keep their training up to date every 3 years.
Medicines Management	Executive Medical Director	24/06/2026	ePMA tap to order duplication - An issue has been encountered across the Health Board where the ePMA tap to order option is used multiple times as ward staff do not realise that it has already been used to order medicines and so the repeat orders have to be cancelled by pharmacy. We were informed that this was considered when developing ePMA but that there were IT issues enabling the ePMA system to communicate with the separate pharmacy system.	Corporate Governance - Internal Audit/2026/1124/MD2/1	We will meet with the ePMA team to review areas where duplicate orders have occurred and address this with the nursing staff to prevent duplicate orders being placed.	31/07/2026	27/07/2026	Amber	Fully complete (Approved)	01/09/2026			Met with the ePMA team who advised that they are encouraging nursing staff to look at the 'Source' of medication tab above the 'Order' button to check where the medication is stored before re-ordering i.e. 'Stock' or 'CD' etc. This information will also be included in the Medication Management training for preceptors which is being updated to reflect ePMA. There is also a working group being formed to look at how medications are transferred when patients move between clinical areas i.e. ED to ward, which will look at improving re-ordering of medications when they've already been dispensed.
Data Warehouse	Director of Digital & Health Intelligence	26/04/2023	The database should be upgraded. A patch strategy should be defined and implemented.	Corporate Governance - Internal Audit/2023/290/MD3/1	The PMS database is planned for upgrade in September/October 2023. Following the upgrade of PMS, the Data Warehouse database will also be migrated to the latest Oracle database and be included within our new Oracle Goldengate infrastructure. A patching strategy will be implemented for both the PMS and Data Warehouse databases.	31/07/2025	29/07/2026	Red	Fully complete (Awaiting approval)	11/05/2023		The PMS Database migration is the highest priority and this needs to be completed before this work is considered.	October 2025 - Warehouse migration onto Oracle 19c is scheduled to take place on 6th November. March 2025 - this work has started on the upgrade. The warehouse cant move to new infrastructure until the PMS upgrade is complete. Work expected to be completed within the next 3 months. July '24 - This work cannot start until the PMS migration completes. We are not expecting this to complete until the later this year (Oct/Nov) Mar '24 - Further delays, again outside our control, have put the migration on hold. The PMS 11g database must be patched to allow Goldengate to be implemented. The SBAR has been presented and approved, work is scheduled to restart with Oracle 15th April. 12/01/26 UPDATE - Warehouse migration and upgrade scheduled for 21st January.
Technical Continuity	Director of Digital and Health Intelligence	24/01/2024	The record of hosted services should be updated to include consideration of RTO/RPO, and all services required to complete the HBA which includes an assessment of impact.	Corporate Governance - Internal Audit/2024/308/MD3/1	Migration of existing HBA spreadsheet to Online dynamic forms for all servers and applications.	01/04/2024	17/06/2026	Green	Fully complete (Awaiting approval)	01/06/2026			July 2024 IA tracker update: June 2024 - HBA spreadsheet has been uploaded into SharePoint although the content has not been fully "Digitised". This further work has been stalled due to resourcing within the team. It is functional but not ideal and is expected to be completed Q4 2024. June 2026 - The HBA document has now been uploaded in MS Teams and is being updated and used from there. The team continue to develop the reporting and validity of the data within the documents.
LIMITED - Estates Condition	Director of Finance	24/01/2024	The Board will be provided with assurances on the effectiveness of the identified actions to reduce the capital asset risks.	Corporate Governance - Internal Audit/2024/309/MD6/1	Agreed in principle. There is an existing agreed capital investment review that is issued to the Board, via the updates provided by the Capital Management Group, and the investment undertaken and the impact thereof on the current estate. What will be included in the future is the impact of this investment on the overall capital requirements of the estate, including understanding depreciation of the estate in the same period of the investment. This will be provided an annual basis. A programme of these updates will be agreed and formulated for the future Board agenda.	31/03/2024	06/07/2026	Red	Fully complete (Awaiting approval)	06/02/2024			Enabling Project work now completed across all sites, the Health Board now have accurate data on the current backlog maintenance situation with accurate cost estimates of backlog that will be updated on an annual basis.
LIMITED - Estates Condition	Director of Finance	24/01/2024	The UHB should clearly defined a process for monitoring and reporting the estates condition on a periodic basis (minimum annually) including the backlog maintenance position.	Corporate Governance - Internal Audit/2024/309/MD5/1	Agreed in principle. The appropriate timing will be agreed with information governance and a report generated in accordance with the recommendation, on an annual basis.	31/03/2024	24/07/2026	Red	Fully complete (Awaiting approval)	06/02/2024			July 2024 IA tracker update: No update received. April 2026 - The Backlog Maintenance position for the health board is reviewed annually and submitted via the NHS Wales Shared Service Estates and Facilities Performance Management System (EFPMS) . In addition to that the recent Estate Wide condition survey that has taken place has provided data that will be maintained and updated as projects to upgrade, renew or refurbish to address backlog maintenance

LIMITED - Estates Condition	Director of Finance	24/01/2024	A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity. Following this, a clear financial model for the revenue support needed to manage the estate should be developed.	Corporate Governance - Internal Audit/2024/309/MD4/1	Agreed in principle - 12 months data has been collated and reports are being run to establish the various levels of staffing required.	23/07/2026	24/07/2026	Red	Fully complete (Awaiting approval)	06/02/2024			Dec 2024 - The formulation of available data has been completed and this has been analysed to provide supportive conclusions to the level of Work force required within Estates. This information along with recent findings associated with the workforce directive within estates has led to a paper being drafted for consideration by the UHB. This paper is currently in draft format with operational leads. APRIL 2026 - An OCP is currently in progress within the Estates Shift Maintenance team to change rota to provide more resilience to coverage. Once this is complete the paper is to be reviewed to understand what workforce will be required. There are recruitment challenges in attracting suitably qualified skilled staff at the salary points that the NHS offers. Requesting additional revenue to bolster staff numbers could still pose problems with recruiting into vacancies
Mortality Reviews	Executive Medical Director	24/04/2024	The Health Board should attempt to: • Clear the backlog of open cases as soon as possible, ideally by its intended deadline of March 2024. • Ensure that new cases are reviewed and responded to on a timely basis.	Corporate Governance - Internal Audit/2024/750/MD2/1	1) Delivery of C&V scrutiny panel to review all cases referred from ME 2) Development of reporting measures to ensure timely internal responses to ME referrals.	30/06/2024	04/02/2026	Green	Fully complete (Awaiting approval)	20/05/2024			Scrutiny panel established and meeting monthely with wide clinical Board representation. Reporting measures delivered and undergoing contiual improvement - presented on 2 occasions to Quality committee
Mortality Reviews	Executive Medical Director	24/04/2024	Ensure that the key priorities for 2024 are effectively implemented.	Corporate Governance - Internal Audit/2024/750/MD3/1	1 – Delivery of C&V scrutiny panel to review all cases referred from ME. 2 – Setting up a Mortality and Morbidity (M&M) Group is in progress. 3 – Making information from the Medical Examiner process available is in progress in conjunction with delivery of ME scrutiny panel. 4 – Bereavement processes T&F group in progress.	01/09/2024	04/02/2026	Green	Fully complete (Awaiting approval)	20/05/2024			All agreed - alignment of M&M process in train incorporating AMAT module
Safeguarding	Jason Roberts	07/10/2024	Ensure that the actions identified within the Improvement Plan are effectively implemented as planned and progress is regularly reported to the SSG.	Corporate Governance - Internal Audit/2024/837/MD4/1	The JIPA improvement plan will be a standard item on the SSG agenda whilst improvements are required to satisfy the UHB that any safeguarding risk is mitigated.	31/10/2024	11/08/2026	Amber	Fully complete (Awaiting approval)	05/11/2024			The JICPA improvement plan was a standing item on the SSG agenda until all actions were completed. Now complete.
LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	2.1 - Progress regarding the All Wales IPFR policy should be monitored so that resolution of the discrepancies is promptly identified. When this occurs, the amended policy should be presented to the Quality, Safety and Experience Committee for adoption, and then made available on the Health Board's intranet and public website. 2.2 - The link to the NHS Wales IPFR Application Form on the public website should be updated so that it works correctly.	Corporate Governance - Internal Audit/2024/926/MD2/1	2.1 - The JCC (formerly WHSSC) met with panel chairs on the 18th of September to discuss the discrepancies with the updated IPFR policy. A number of wording discrepancies in the IPFR policy were identified. The IPFR Policy is currently being reviewed, and the final version of the IPFR Policy will be shared and sent to the Health Boards for approval. The Lead for Clinical Commissioning/IPFR has not confirmed a completion date or when we are likely to receive a final version of the IPFR Policy.	31/03/2025	09/04/2026	Amber	Fully complete (Awaiting approval)	04/02/2025		Awaiting National action to complete locally. No deadline/due date provided at this time.	Feb 2026 - The Individual Patient Funding Requests (IPFR) Policy was approved at CAVUHB Board on 29th January 2026.
LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	3.1 - The reason for data being changed should be identified and corrective action taken as this should not occur. 3.2 - The difference in the number of INNU procedures between the Health Board's report and its policy list should be reviewed and resolved. 3.3 - Where significant numbers of INNU cases are recorded, they should be investigated, and corrective action taken where necessary by the Clinical Boards. 3.4 - Where 'dummy' clinicians are listed, they should be investigated, corrected and action taken to prevent recurrence.	Corporate Governance - Internal Audit/2024/926/MD3/3	3.3 - The INNU procedure monitoring list will be reviewed by the Value in Health Programme monthly. Quarterly, each clinical board will be required to review the top 5 interventions with the highest procedure count over the period. They will be requested to review the appropriateness of these procedures against the INNU policy and provide feedback and an action plan if needed to the INNU working group.	31/03/2025	27/07/2026	Amber	Fully complete (Awaiting approval)	04/02/2025			July 2026 - there is now a programme of spot audits targetting Acne, tonsilectomy and hip prosthesis. The majority of acne records that pull through on the BIS report are skin cancers - this is because the nationally directed procedure code is "excision of skin" which can relate to a range of interventions. From these audits I am assured that there is limited to no acne activity going through. These checks will be repeated monthly. The tonsilectomies have also been audited by a senior clinician with all 50 meeting the criteria. This will be repeated on a quarterly basis. Next to target are those that pull through as hip prosthesis. March 2026 - action reopened from instruction by Joanna North. Agreed with Internal Audit. April 2025 - Action approved on behalf of Claire Beynon, Michael Allum, and Annie Ashman (email saved in documents). Feb 2025 - A monthly BIS report of interventions completed is distributed to all clinical board leaders for review and action. Their review and any corrective action will be reported into clinical board Quality and Safety meetings and the Health Board QIEP/productivity and efficiency report for Executive review. We have reviewed high-volume interventions such as Varicose Veins,

LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	3.1 - The reason for data being changed should be identified and corrective action taken as this should not occur. 3.2 - The difference in the number of INNU procedures between the Health Board's report and its policy list should be reviewed and resolved. 3.3 - Where significant numbers of INNU cases are recorded, they should be investigated, and corrective action taken where necessary by the Clinical Boards. 3.4 - Where 'dummy' clinicians are listed, they should be investigated, corrected and action taken to prevent recurrence.	Corporate Governance - Internal Audit/2024/926/MD3/4	3.4 - The INNU working group will investigate the reason for using 'dummy' clinician listings and confirm a process to review these.	31/03/2025	27/07/2026	Green	Fully complete (Awaiting approval)	04/02/2025			July 2026 - there are no dummy clinicians listed in the July INNU BIS report. March 2026 - action reopened from instruction by Joanna North. Agreed with Internal Audit. April 2025 - Action approved on behalf of Claire Beynon, Michael Allum, and Annie Ashman (email saved in documents). March 2025 - Dummy clinician is selected within the service listing processes. Each service utilising this will be contacted and requested to preform corrective action (retrospectively and prospectively ideally). Discussion with Planned Care Programme is also being held to identify if there is a catch-all process that could be completed to eradicate its use.
LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	6.1 - The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete. 6.2 - All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur. 6.3 - An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. 6.4 - Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	Corporate Governance - Internal Audit/2024/926/MD6/2	6.2 - As per response in 3.3	31/03/2025	27/07/2026	Red	Fully complete (Awaiting approval)	04/02/2025			July 2026 - I am now leading on spot auditing the INNU report. March 2026 - action reopened from instruction by Joanna North. Agreed with Internal Audit. April 2025 - Action approved on behalf of Claire Beynon, Michael Allum, and Annie Ashman (email saved in documents). March 2025 - A routine for retrospective review has been established where the monthly BIS report of interventions completed is distributed to all clinical board leaders for review and action. Their review and any corrective action will be reported into clinical board Quality and Safety meetings and the Health Board QIEP/productivity and efficiency report for Executive review. The Value in Health Programme is supporting the review where required.
LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	6.1 - The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete. 6.2 - All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur. 6.3 - An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. 6.4 - Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	Corporate Governance - Internal Audit/2024/926/MD6/3	6.3 - As per response in 3.3	31/03/2025	27/07/2026	Red	Fully complete (Awaiting approval)	04/02/2025			March 2026 - action reopened from instruction by Joanna North. Agreed with Internal Audit. April 2025 - Action approved on behalf of Claire Beynon, Michael Allum, and Annie Ashman (email saved in documents). March 2025 - Clinical board leaders will be responsible to review their monthly INNU lists and take corrective action where necessary. This review and action will be reported into the clinical board Quality and Safety meetings and the Health Board QIEP / productivity and efficiency report for Executive review.
LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	4.1 - For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy has been met. 4.2 - Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	Corporate Governance - Internal Audit/2024/926/MD4/1	4.1 - We will work with clinical leads to ensure that a clear record is retained within the patient record to demonstrate compliance with the INNU policy if there is a clinical exception.	31/03/2025	27/07/2026	Red	Fully complete (Awaiting approval)	04/02/2025			July 2026 - we are seeking assurance on this by spot auditing the high volume pathways. March 2025 - Along with the intervention audits, processes for listing and documenting compliance with the INNU policy are being reviewed. Request to extend to complete the necessary the work with clinical boards – June 2025

LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	4.1 - For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy has been met. 4.2 - Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	Corporate Governance - Internal Audit/2024/926/MD4/2	4.2 - We will work with the clinical leads to develop an appropriate process to do this. We will consider good practice existing within the health board, such as the tonsillectomy pathway to inform the process we will take across the piece.	31/03/2025	27/07/2026	Red	Fully complete (Awaiting approval)	04/02/2025			July 2026 - we have put in a process to spot audit retrospectively to determine whether interventions are needed prior to listing. Tonsillectomies have been shown to be using the correct records and checklist. March 2026 - action reopened from instruction by Joanna North. Agreed with Internal Audit. April 2025 - Action approved on behalf of Claire Beynon, Michael Allum, and Annie Ashman (email saved in documents). March 2025 - It has been determined that it is likely that we will need an independent check to be made. Following this action, there is a proposition in development to create a MDT panel to review waiting list cases and agree appropriate action- i.e. continue to treat or return to referrer for alternative management.
LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	5.1 - 'Do-Not-Do' intervention 'Nasal surgery for snoring' should be included in the Health Board's INNU monitoring report so that occurrence of cases can be monitored.	Corporate Governance - Internal Audit/2024/926/MD5/1	An OCPS code for this procedure is not provided on the All Wales Guidance List. As mentioned above, our digital and information team will endeavour to source an alternative code to track this procedure. If not possible, this will be escalated to the National Clinical Effectiveness Group.	31/03/2025	26/08/2026	Green	Fully complete (Awaiting approval)	04/02/2025			August 2026 - Completion note added (coding agreed in May 2025): codes were agreed locally with service and operations leads. Information Manager involved made clear at the time this would be a local addition and therefore not on the national list. The coding was agreed by DHCW, so not just local. April 2025 - An OCPS code for this procedure is not provided on the All Wales Guidance List. The National Working Group lead has been contacted and responded that this intervention is on the NHSE list and not yet evidence reviewed, therefore can not advise on a code. Coding lead for Health Board has been contacted. Request to extend as awaiting National guidance -June 2025.
LIMITED Follow Up: Implementation of Health Roster System	Executive Director of People and Culture / Executive Nursing Director	07/01/2025	Rosters need to be published on time in line with the roster timetable and also approved.	Corporate Governance - Internal Audit/2025/257/MD3/1	In response to many rosters not being published 6 weeks before they commence, a new monthly report has been developed to identify both the number and percentage of wards/departments who are not issuing their rosters on time for each Clinical Board. This is presented at the Nursing and Productivity Group each month to ensure this is being performance managed by the Clinical Board Directors of Nursing. However, due to the current way that theatre lists are configured, this means that the same target for peri-operative staff cannot be included at this time but will however aim to achieve this same objective but over a longer period.	01/04/2025	13/04/2026	Red	Fully complete (Awaiting approval)	04/02/2025			This action is held with the E-rostering team, Paul Jones. The E-rostering team is circulating this report monthly to the directors of nurses for the clinical board. This report is also shared with the Nursing Productivity Group. 25/3/26- A monthly report is being sent to the Directors of Nursing for each Clinical Board to identify areas that have not issued their rosters on time. In ongoing work the Nurse Staffing Lead will monitor and identify areas who repeatidly do not publish rosters in a timely manner to focus on reasons for this and establish a plan moving forward to improve the practice of publishing late rosters.
LIMITED Follow Up: Implementation of Health Roster System	Executive Director of People and Culture / Executive Nursing Director	07/01/2025	Roster Managers should ensure that they are finalising shifts in a timely manner. Clinical Board Director of Nurses need to emphasise the importance to the Roster Managers of finalising the shifts.	Corporate Governance - Internal Audit/2025/257/MD6/1	Although the verification of bank and agency shifts is no longer an issue, the verification of substantive shifts within the Clinical Boards requires improvement. A report is now presented monthly at NPG to identify the number of shifts that are not approved by the payroll deadline and then have to be cancelled. The report will enable the Executive Director of Nursing to performance manage this issue on an ongoing basis. A further communication will be developed and sent to all Ward Sisters and Charge Nurses explaining that the deadlines need to be complied with as it delays the payments to their staff and also results in them having to do additional work by re-entering the shift on health Roster and then verifying.	01/04/2025	13/04/2026	Red	Fully complete (Awaiting approval)	04/02/2025			The e-rostering team oversee this action and produce the report. This would be reported to NPG. 25/3/26 A report is sent to Directors of Nursing for each Clinical Board and monthly meetings are held by the E-rostering team with managers to manage the shifts that have not been approved. The payroll dates now align within the current month which is a recent change but does mean the number of days managers have to verify shifts has reduced.

LIMITED Follow Up: Implementation of Health Roster System	Executive Director of People and Culture / Executive Nursing Director	07/01/2025	E-Rostering team need to continue to work with Corporate Nursing to ensure that staff balances are being managed adequately.	Corporate Governance - Internal Audit/2025/257/MD5/1	There have been some significant improvements in managing the hours owed but it is accepted that this needs to be performance managed on an ongoing basis within the Clinical Boards. However, it needs to be noted that there will be a number of situations such as staff on sick leave and maternity leave who will be unable to work the hours back within specific timeframes.	07/01/2026	13/04/2026	Green	Fully complete (Awaiting approval)	04/02/2025			A net hours report is being sent out monthly by the e-rostering team to the clinical board director of nurses. This has also been shared with the EDON and discussed at the nursing productiveity group for oversight. 25/3/26- The Executive Nurse Director has agreed that staff must have 18 hours or less time owing to allow them to book a bank shift which will encourage staff that owe additional hours to reduce this number to allow then to work additional shifts on the bank. Regular reports (2 weekly) are also sent to Directors of Nursing for the Clinical Boards so the staff members can be performance managed
LIMITED - Surgery Clinical Board - Consultant Job Plans Follow Up	Chief Operating Officer	05/03/2025	Orthopaedics and General Surgery - Management should ensure that all Consultants have a new job plan or a job plan that has been reviewed (republished) and fully signed off within the last 12 months. Where job plans have been agreed verbally by the Consultant but not signed off by them on the system, consideration should be given to developing a proxy sign off process to facilitate full and timely sign off. Orthopaedics - The Manager sign off requirements for Orthopaedics job plans should be amended to ensure that the first and second sign-offs are not the same Manager.	Corporate Governance - Internal Audit/2025/689/MD2/1	This review has been helpful. All consultants in T&O have an agreed job plan, however we have identified that the ones that the system categorises as expired are not in reality expired it is that there were no changes at the point of meeting. Where we have to reset the start date after 12 months, the system undoes the sign off, so they appear not signed off even though a meeting and review has taken place. The feedback from this audit has led to an introduction in sign off at the meeting stage for consultants where no changes have occurred. We have a set shirt target date to enable swift monitoring and implementation of this change.	31/05/2025	28/07/2026	Red	Fully complete (Awaiting approval)	20/05/2025			Shannon Ocallaghan assured me that after a discussion with Kirsten Mansfield that Allocate is now configure for her to be first sign off as Directorate Manager with the CDs (Alun John / Khitish Mohanty / Mike McCarthy) being second sign off. Kirsten Mansfield has also provided us with document which we have shared with CDs and DMs to republish a JP easily if no changes were made during the Job Planning meeting.
LIMITED - Surgery Clinical Board - Consultant Job Plans Follow Up	Chief Operating Officer	05/03/2025	Orthopaedics and General Surgery - All Consultant job plans with more than 12 sessions per week should be approved in line with the Consultant Job planning Procedure. If feasible the approval should be evidenced on the Allocate system using the third sign off field.	Corporate Governance - Internal Audit/2025/689/MD4/1	We acknowledge more work is required in this area. Since the review the Clinical Board has set up a quarterly CD Forum and a standing agenda item is Consultant Job Planning. The intention being to continuously review our process and ensure actions are implemented so that we achieve our aim of implementing standard principles across all specialties.	30/09/2025	28/07/2026	Amber	Fully complete (Awaiting approval)	20/05/2025			All Job Plans in the SCB above 12 sessions were reviewed by myself (CBD) during last years Job Planning cycle: In Urology sessions above 12 were in place to facilitate clinical delivery due to the inability to recruit consultants. We are finally now in a position to bring this down to 12 when we appoint last consultant as part of the workforce rightsizing in Urology. In General Surgery consultants above 12 sessions are in clinical lead roles (CD, Audit, UGI, LGI, HPB) or are backed by external funding from other HBs or research. I have discussed these job plans with Mike Stephens (AMD for Workforce) and David Fluck (MD) as part of the financial meeting over the last financial year. Provided these sessions are delivered they are the most cost effective way of delivering the service as there are no pension or SPA component to pay. I have asked if Allocate can be set up for a 3rd sign off for all JPs above 12 sessions by myself. At present I only sign off the Clinical Director's JPs. Kirsten Mansfield advised that building an automatic third sign off by myself is not currently possible in Allocate. I will continue to review sessions above 12 in all directorates in the SCB.
Business Continuity Planning	Chief Operating Officer	14/04/2025	Guidance - Business Continuity Planning Guidance (UHB 400) comprehensively addresses the guidance requirements in relation to the Business Continuity planning process and provides suitable instructions in the production of Business Continuity plans. However, some confusion by the plan producers was identified with respect to the recording of issue/review dates, and the categorisation of critical services.	Corporate Governance - Internal Audit/2025/850/MD2/1	The EPRR will produce a training course aimed at Business Continuity Leads to assist them with the business continuity plan review process. It is intended that the course will be run twice a year. Bespoke training designed. Will be delivered twice yearly. Presently unable to proactively progress delivery due to budgetary Standing Financial Orders (staff not being released for training). This has been added to the EPRR Risk Register.	05/03/2025	02/04/2026	Amber	Fully complete (Awaiting approval)	20/05/2025	Presently unable to proactively progress delivery due to budgetary Standing Financial Orders (staff not being released for training). This has been added to the EPRR Risk Register. Dedicated training program will not be delivered until 2026	Presently unable to proactively progress delivery due to budgetary Standing Financial Orders (staff not being released for training). This has been added to the EPRR Risk Register. Dedicated training program will not be delivered until 2026	Presently unable to proactively progress delivery due to budgetary Standing Financial Orders (staff not being released for training). This has been added to the EPRR Risk Register. Dedicated training program will not be delivered until 2026 Training course has been developed and a copy attached

Risk Management and Board Assurance Framework	Director of Corporate Governance	20/04/2026	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.	Corporate Governance - Internal Audit/2026/1104/MD3/1	The Digital Risk Lead will work with the team organising the Clinical Board Executive Reviews to formalise the risk information that is submitted for each of the review meetings.	30/09/2026	23/07/2026	Amber	Fully complete (Awaiting approval)	19/05/2026			Discussed at ORMG - CBs to reach out if further advice required. Data shared with CBs to standardise risk tables submitted. These have appeared as top 5 risks at CB Reviews. July 2026- this action is scheduled for discussion at the ORMG in July to drive and strengthen a consistent approach for reporting risks into CB reviews.
Occupational Health Services	Executive Director of People and Culture	28/04/2026	SharePoint Information - Information for the Occupational Health Service can be found on a standalone Occupational Health Service SharePoint page as well as subpages within the People and Culture SharePoint pages. Our review of the information saved on these pages found inconsistencies with the information available to staff. We also noted that there is limited information on how staff are able to self-refer themselves to the Occupational Health Service and that there is no information saved regarding Health Surveillance.	Corporate Governance - Internal Audit/2026/716/MD3/1	We will remove all information related to the Occupational Health Service from the People and Culture SharePoint page and replace with a direct link to the Occupational Health page. We will ensure that clear details regarding staff self-referrals to the service and Health Surveillance is added to the department's page.	31/07/2026	07/08/2026	Amber	Fully complete (Awaiting approval)	19/05/2026			I have been assured that information from the P&C SharePoint has been removed and replaced with a link to the OH SharePoint. The self-referral information for our staff has been improved and Health Surveillance has been added appropriately
Five Steps to Safer Surgery	Executive Medical Director	22/05/2026	Policies and Procedures - The Five Steps to Safer Surgery procedure is dated March 2022 and is overdue for review. We understand this is being reviewed by the WHO Collaborative, although there is no timescale for completion. Many of the clinical and non-clinical policies and procedures on the Perioperative Directorate SharePoint page are similarly overdue for review. The Perioperative Directorate Policy and Procedure Group minutes are published on SharePoint, however, the most recent published minutes are dated 23rd March 2023, despite the Group continuing to meet. The Perioperative Care Directorate Quality & Safety Group terms of reference provided to us for review was dated June 2011. The Directorate were unable to provide a copy of the Policy and Procedure group terms of reference.	Corporate Governance - Internal Audit/2026/1084/MD1/1	All of our out-of-date Directorate policies and procedures will be reviewed and updated, and we will resume posting the Policy and Procedure group minutes on SharePoint. The terms of reference for the Perioperative Care Directorate Policy and Procedure Group and the Quality and Safety Group will be reviewed.	30/06/2026	17/07/2026	Red	Fully complete (Awaiting approval)	01/09/2026			all out of date policies and procedures updated and uploaded to SharePoint. Terms of reference developed and ratified and shared amongst directorate. Current policies and procedures under review labelled as Draft and placed on Sharepoint. Highlighted at policy and procedure group meeting and allocated to specific staff to undertake review. Policies that have been reviewed have been updated and added to sharepoint, as are policy minutes. Remaining policies that are still at draft stage due to current investigations and reviews are clearly labelled with draft. These will be updated on completion
Leadership and Management Training / Development	Executive Director of People and Culture	28/05/2026	Engagement with Clinical Board Senior Management to promote awareness of Programmes - Engagement to Clinical Boards and corporate functions in 2025/26 is ongoing with a view to sharing current training courses available. However, this ongoing plan is work in progress and should be complete by June 2026.	Corporate Governance - Internal Audit/2026/1120/MD2/1	The Education Team and Leadership and Management will liaise with Clinical Board Triumvirates, Corporate Function and appropriate leadership teams to discuss and promote their respective educational Programmes to ensure maximisation of awareness of the courses on offer to all staff groups.	31/07/2026	30/07/2026	Amber	Fully complete (Awaiting approval)	01/09/2026			Expected Evidence of Implementation: • Engagement schedule • Completion recorded over time • Regular advertising on multiple platforms i.e viva engage, Ask Suzanne, relevant professional meetings Please see the uploaded document that outlines the stakeholder engagement, hours, format etc. This includes: attendance at clinical board SMTs, Ask Suzanne attendance, other relevant groups and activities including Leadership Conference, Viva Engage activity etc. This satisfies completion of the action.

Risk Management and Board Assurance Framework 2025	Director of Corporate Governance	02/04/2025	Review of Strategic Risks - The strategic risks contained within the BAF are being reviewed on a regular basis through presentation to the Board but there is little evidence of the more detailed review intended for the board sub-committees taking place with the exception of those risks linked to the People and Culture agenda. The cover Board paper for the BAF does not highlight any key messages in terms of specific risks that Board members may need to be alerted to.	Corporate Governance - Internal Audit/2025/941/MD2/1	The sub-committees of the Board will ensure that their agenda includes review of the strategic risks allocated to them in the BAF. The cover Board paper for the BAF will contain a brief update on any key messages in the overall management of strategic risks where appropriate.	30/09/2025	25/08/2026	Amber	Partially complete (Overdue)	20/05/2025			January 2026 update - The last 3 BAF cover reports for Board contains brief updates on key messages in the overall management of strategic risks where appropriate. The BAF is now going to P&C with specific themes to each meeting and then we've started to take it to F&P more recently too (decarbonisation). Quality Committee is having a focus on the strategy and the portfolios driving work which in turn brings discussions to the BAF. This action is now complete. April 2026 Risk Management & Board Assurance Framework internal audit report noted that this action was still ongoing and provided the following update against this action: 'The cover paper for the BAF and the CRR contain a section entitled Executive Director Opinion and Key Issues to bring to the attention of the Board. This provides a useful summary for the BAF and currently an oversight of risks by type and age for the CRR. There is demonstrable progress with the sub-committee review of the risks allocated to them in the BAF with all but the Quality Committee having BAF related items regularly on the agenda. The Quality Committee is currently considering how best to manage and monitor the risks allocated to it. However, the approach across the other Committees is inconsistent and would benefit from having a relevant extract from the BAF on the agenda as a specific reminder of the risks allocated to each Committee'. Action