Inspection Title	External Inspection Lead	Inspection Date	Recommendation	Reference Number	Action	Service	Due Date	Action Rating	Progress Status	Audit Committee	Risks	Barriers	Comments/Updates
Data Warehouse	Director of Digital & Health Intelligence	26/04/2023	A data strategy should be fully defined, along with a supporting roadmap. This should consider the appropriateness of the warehouse for the future. We note that there is a large amount of valuable information and reporting being provided from the data warehouse. To start anew would be a resource intensive undertaking, however the warehouse may not be able to fully provide a modern analytics function. As such the capability of Jupyter workbooks should be fully assessed to ensure it is capable of meeting the demands of the organisation.	Corporate Governance - Internal Audit/2023/290/MD7/1	We are committed to and are working to develop a data strategy which will address the warehouse issue raised but also the wider issue of providing data to those that need it.	Digital and Health Intelligence	31/03/2024	Amber	Partially complete (Overdue)	11/05/2023			October 2025 - alongside the data strategy work has been undertaken to build dimensional data products in a new analytics database, adopting a medallion architecture, March 2025 - things have moved on, the new overarching data strategy is being produced by the Chief Clinical Information Officer (CCIO). June 2024 - No Update Mar '24 - Data strategy being developed and led by the CCIO feeding into the data Insights work programme.
Information Governance	Director of Planning and the Digital of Digital and Health Intelligence	29/02/2024	Management should consider identifying appropriate IG Leads / Champions within the Health Board, and to support the IG team by promoting good information governance practice.	Corporate Governance - Internal Audit/2024/747/MD2/1	With the existing limited capacity, ensuring that other departments have staff with specific data protection responsibilities is desirable but we need to ensure that this doesn't adversely impact their primary roles which, in the main, are already under strain. One role that needs to be conducted is the role of a Information Asset Owner (IAO) who should be responsible for completing a Information Asset Register (IAR) for their area. It would therefore make sense to explore whether the scope of this role could be extended to also include other data protection responsibilities, such as breach reporting/management and a general IG point of contact for their department.	Digital and Health Intelligence	01/04/2024	Amber	Overdue	20/05/2024	As above, unless the UHB is able to document its assets, effectively and appropriate management is very difficult resulting in a wide range of risks.	Dedicated resource and a platform to record.	May 2025 update: IARs remain a major IG, cyber, disaster recovery and business continuity risk. Whilst there is support from the board to complete, resource to undertake this exercise and the absence of a IAR platform result in a continued lack of progress. January 2026 update: Clinical Boards have been made aware of the need to implement and assign IAOs. Cyber will ensure that appropriate framework/guidance is in place to allow these roles to be supported.
Technical Continuity	Director of Digital and Health Intelligence	24/01/2024	The DR plan should be updated to include: • Procedures or signposting to procedures for varying failure types • Updating for the new architecture • Prioritised order of restoration, which is agreed with services • Explicit consideration of RTO/RPO Services should be requested to provide DR plans that synchronise with the Digital Directorate. As part of this the RTO/RPP provided by digital should be agreed.	Corporate Governance - Internal Audit/2024/308/MD5/1	As part of the NIS 2 Directive there is an expectation that all "Critical" systems have resilience. Often this is overlooked due to cost and lack of technical information provided at the point of implementation. A task to go through all the systems and confirm resilience, RPO and RTO abilities has started and will continue for the foreseeable future.	Digital and Health Intelligence	01/04/2024	Red	Partially complete (Overdue)	06/02/2024			July 2024 IA tracker update: June 2024 - The revised DR plan is currently under review and being updated by the CAV IT/Cyber team. May 2025: Head of Cyber unsighted on action or audit report. The draft updated DR plan has been shared with Digital Ops to review and update. January 2026: Head of Cyber has requested an update on this action from Head of Digital Ops. Will update record once received.
Medical Records Tracking (CD&T CB) Follow-Up	Chief Operating Officer	06/06/2024	Management should ensure that on establishment of the new Clinical Information Programme Board, a system is put in place to oversee the 'Tracking of Medical Record Learning and Improvement Proposal' when the proposal is developed.	Corporate Governance - Internal Audit/2024/258/MD13/1	The improvements within the 'Tracking of Medical Record Learning and Improvement Proposal' will be incorporated within the workstreams of the Clinical Information Programme, with progress against these monitored by the Clinical Information Programme Board.	Clinical Diagnostics & Therapeutics	30/06/2024	Amber	Overdue	02/07/2024			August 2026 - CIP meetings have been stood up for a while. It has not run for a number of months. However, key aspects of the programme have been taken through other initiatives, such as the Coding Improvement Plan and Scan to Code initiative supported by Shaping Change.
Medical Records Tracking (CD&T CB) Follow-Up	Chief Operating Officer	06/06/2024	Management should ensure the scheduled periodic checks are undertaken on a regular basis. Acknowledging the progress highlighted, management should ensure a 'specific plan' detailing the progress of the universal filing system is developed.	Corporate Governance - Internal Audit/2024/258/MD15/1	A plan for achieving full LBF in rooms 4 and 5 will be updated, including presenting options to improve timelines. Progress against this will be outlined at the monthly Directorate Performance reviews with the CD&T Clinical Board, as will quality control metrics; principally results of spot check audits. It will link into the Clinical Information Programme as part of its 'Consistency of Approach' workstream where assessment of practice occurs and where recognised good exemplars are shared.	Clinical Diagnostics & Therapeutics	30/06/2024	Green	Overdue	02/07/2024			August 2026 - significant progress in achieving full Location Based Filing in rooms 4 and 5 has been made with the majority of room 4 - the largest library by some margin - however, administrative as well as environmental challenges have prevented completion. The department is currently continuing with the plan on a best endeavours basis.
Medical Records Tracking (CD&T CB) Follow-Up	Chief Operating Officer	06/06/2024	Management, in relation to their previous management response, should ensure that the new Clinical Information Programme Board develop a Communications Strategy to remind staff of their responsibilities to return and record health records, in line with the points within the letter from the Ombudsman.	Corporate Governance - Internal Audit/2024/258/MD14/1	As part of the Clinical Information Programme Board's communication campaign, responsibility for the appropriate handling and transfer of clinical records will be emphasised widely across the UHB. These obligations will also be reinforced through the Medical Director's new Clinical Information Management Group.	Clinical Diagnostics & Therapeutics	31/07/2024	Red	Overdue	02/07/2024			August 2026 -whilst the Clinical Information Group has not been established, wide communications have gone out, most recently via the Executive Director of Nursing. Further communications are imminent to help increase the availability of medical records for timely clinical coding.

Medical Records Tracking (CD&T CB) Follow-Up	Chief Operating Officer	06/06/2024	Management should ensure that the terms of reference for the new group is produced, and the group is established as soon as possible to provide effective oversight of medical records matters.	Corporate Governance - Internal Audit/2024/258/MD12/1	Terms of reference for the Clinical Information Management Group will be agreed by the Interim Medical Director prior to being formally taken to the Group's inaugural meeting. A schedule of future meetings will be arranged, within which the terms of reference will be approved.	Clinical Diagnostics & Therapeutics	31/08/2024	Amber	Overdue	02/07/2024			August 2026 - the group hasn't been established, no ToRs established. Linked to the Audit Wales Clinical Coding from 2014.
Specialist Services Clinical Board Governance and Financial Management Arrangements	Chief Operating Officer	24/10/2024	1.1 - The Specialist Clinical Board should maintain oversight of key decision-making groups and governance forums and ensure that these are governed by approved Terms of Reference. 1.2 - The Specialist Services Clinical Board should also maintain records of Terms of Reference in place, their ownership and the required review dates to ensure a timely process for ToR review/update.	Corporate Governance - Internal Audit/2024/854/MD1/1	1.1 - The Clinical Board governance structure will be updated to reflect the various decision-making groups in the Clinical Board, together with copies of the Terms of Reference for each of the groups. This will be stored in the Clinical Board Teams folder.	Specialist Services	30/11/2024	Red	Overdue	05/11/2024			
Specialist Services Clinical Board Governance and Financial Management Arrangements	Chief Operating Officer	24/10/2024	2.1 - The Specialist Services Clinical Board Management should ensure that agendas, minutes and action logs are documented for all decision-making groups and governance forums. Arrangements must be put in place to ensure that outstanding actions are reviewed at each meeting with clearly recorded progress on the actions recorded.	Corporate Governance - Internal Audit/2024/854/MD2/1	2.1 - An action log will be produced and circulated for the Directorate Performance Review meetings commencing with the meetings arranged for Quarter 3 24/25. These action logs will be reviewed and updated each quarter at subsequent Directorate Performance Review meetings.	Specialist Services	31/12/2024	Amber	Overdue	05/11/2024			
Patient Safety Incident Management	Executive Nurse Director	05/04/2024	Management should ensure that incidents are processed within the expected timeframes and reported as stated in the Welsh Government policy, Welsh Government supporting documents and Health Board policy and procedure. Management should also review the incident process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays. The Health Board should ensure where lessons learnt have occurred improvement plans are completed. With the continuous adoption and use of AMaT by the Health Board, it would be good practice to indicate within Datix that the incident has an improvement plan recorded on AMaT. Also, in situations where improvement plans have been developed in themes rather than the identifiable incident ID number, a means of identification would be helpful to link	Corporate Governance - Internal Audit/2024/749/MD3/1	1a. Quarterly emails to incident managers from the Datix Central Team to highlight overdue incidents. 1b. Patient Safety Team and Clinical Board QSE leads with support from Superusers to identify and support incident managers with long standing overdue incidents to support them in managing and closing their incidents. 1c. Management of overdue Datix Incidents has been identified as a performance measure for 2024 /2025 with a goal to reduce incidents open for over 90 days by 60% from the April 2024 bench mark by the end of Q3 1d. Executive Performance Reviews to include need for assurance on timely incident management within the 1e. Clinical Boards, queue position to be added to the assurance report. 2. Datix team to explore with Datix Central Team the inclusion of an additional field to reference AMAT entry. Explore with Clinical Assurance Team the inclusion of a Datix reference onto AMAT. Until the above is completed, ensure for NRIs that improvement plans are referenced in the	Corporate Nursing	31/12/2024	Amber	Partially complete (Overdue)	20/05/2024		Operational pressures impact on the time incident managers have to manage datix incidents.	July 2026 - Patient Safety Team have taken this as far as they can, but the number of overdue incidents is still high. Update 23.10.25 - Since August 2025 the PST have been providing one to one sessions with incident managers to help them confidently manage open incidents, this allows them to have support closing old open incidents and be able to proactively manage new incidents. In January 2024, the number of open incidents was 8236, in September 2025 the open number was 5,900, this is a drop of 28%. Incidents open more than 90 days has dropped from 2398 in January 2024 to 2032 in September 2025, this is a drop of 15%. The one to one sessions are a new initiative and will continue however with a proactive approach of addressing incident managers with the highest queues. Those with the highest queues have been shared with their respective Clinical Boards with the suggestion that they encourage those to book on. However, it was found that most attending had few or none open incidents, so while it was helpful to refresh them on datix, it didn't have the outcome we wanted in terms of reducing long standing open incidents. A chart showing the trend of open incidents by
Maternity Care - Ockenden Review	Executive Nurse Director	19/08/2024	1.1 - Action plans relating to the reviews and reports which were incorporated into the combined assurance document should be reviewed. Status updates should be recorded against all actions and actions should be closed where appropriate. In cases where actions are carried forward to another action plan, this should be recorded in the original action plan, including reference details of the superseding action. 1.2 - It should be assured that target dates are defined and that responsible individuals are designated in respect of each agreed action of the Assurance and Exception Reporting Tool. In cases where recommended actions are not agreed, information to show that the recommendation has been considered should be recorded. 1.3 - Action plans should be regularly reviewed in accordance with a prescribed schedule, and in response to progress milestones being achieved. Status updates should be entered against each action and	Corporate Governance - Internal Audit/2024/847/MD1/2	1.2 - It should be noted that when inputting Inspections/ Inspection Actions into the AMaT system, it is a system requirement to allocate a Responsible Person, to assign a Due Date and confirm an Action rating. This is, therefore, a forced function in the context of AMaT Inspection publications. The below actions are posed to further support outstanding Inspection Action completion. Review the Inspections/ Inspection Actions via the AMaT system during the Midwifery and Nursing Senior Leadership Board ensuring that the following details are confirmed with the attending Senior Management Team; - Appropriate allocation of person responsible for action, - Confirmation of Specific, Measurable, Achievable, Relevant and Time-Bound actions, - Appropriate proposed timeframe for action completion, - Evidence required for action completion, - Progress Status. Once Inspection Actions are assigned to a responsible person, the individual will be	Children & Women	10/02/2025	Amber	Overdue				

Maternity Care - Ockenden Review	Executive Nurse Director	19/08/2024	1.1 - Action plans relating to the reviews and reports which were incorporated into the combined assurance document should be reviewed. Status updates should be recorded against all actions and actions should be closed where appropriate. In cases where actions are carried forward to another action plan, this should be recorded in the original action plan, including reference details of the superseding action. 1.2 - It should be assured that target dates are defined and that responsible individuals are designated in respect of each agreed action of the Assurance and Exception Reporting Tool. In cases where recommended actions are not agreed, information to show that the recommendation has been considered should be recorded. 1.3 - Action plans should be regularly reviewed in accordance with a prescribed schedule, and in response to progress milestones being achieved. Status updates should be entered against each action and	Corporate Governance - Internal Audit/2024/847/MD1/1	1.1 - Review the Audit Management and Tracking (AMaT) system to ensure all action plans relating to the reviews and reports which were incorporated into the combined assurance document are present, enabling appropriate monitoring of required actions and increased oversight. In the event that outstanding action plans as detailed above are not already inputted into the AMaT system for the purpose of tracking/ oversight, this should be rectified with immediate effect. Review the Inspections / Inspection Actions* as detailed above via the AMaT system during the Midwifery and Nursing Senior Leadership Board meeting ensuring that the following details are confirmed with the attending Senior Management Team; - Appropriate allocation of person responsible for action, - Confirmation of Specific, Measurable, Achievable, Relevant and Time-Bound actions, - Appropriate proposed timeframe for action completion, - Evidence required for action completion,	Children & Women	10/03/2025	Amber	Overdue				
Maternity Care - Ockenden Review	Executive Nurse Director	19/08/2024	1.1 - Action plans relating to the reviews and reports which were incorporated into the combined assurance document should be reviewed. Status updates should be recorded against all actions and actions should be closed where appropriate. In cases where actions are carried forward to another action plan, this should be recorded in the original action plan, including reference details of the superseding action. 1.2 - It should be assured that target dates are defined and that responsible individuals are designated in respect of each agreed action of the Assurance and Exception Reporting Tool. In cases where recommended actions are not agreed, information to show that the recommendation has been considered should be recorded. 1.3 - Action plans should be regularly reviewed in accordance with a prescribed schedule, and in response to progress milestones being achieved. Status updates should be entered against each action and	Corporate Governance - Internal Audit/2024/847/MD1/3	1.3 - Review the Inspections/ Inspection Actions via the AMaT system during the Midwifery and Nursing Senior Leadership Board meeting ensuring that the following details are confirmed with the attending Senior Management Team; - Appropriate allocation of person responsible for action, - Confirmation of Specific, Measurable, Achievable, Relevant and Time-Bound actions, - Appropriate proposed timeframe for action completion, - Evidence required for action completion, - Progress Status. Where possible/ applicable, status updates can be advised during the Midwifery and Nursing Senior Leadership Board meeting with further superseding actions confirmed to support recommendation completion if required. These superseding actions should be detailed for monitoring purposes within the Nursing and Senior Leadership Board meeting minutes, as well as noted on the relevant Inspection Action in the Updates/ Comments section via the AMaT system.	Children & Women	10/03/2025	Amber	Overdue				
Maternity Care - Ockenden Review	Executive Nurse Director	19/08/2024	2.1 - The scope of the Maternity and Neonatal Oversight Group should be reviewed, and it should be ensured that the monitoring of progress against action plans is highlighted as a core function of the group. 2.2 - Regular status updates should be reported to the Quality, Safety and Experience Committee with respect to overall progress against implementing actions recommended by external reviews.	Corporate Governance - Internal Audit/2024/847/MD2/1	2.1 - The Terms of Reference for the Matneo oversight group should be reviewed, agreed and updated accordingly by key stakeholders/ meeting attendees, ensuring the monitoring of progress against action plans is highlighted as a core function. The fixed agenda for the MatNeo oversight group should be reviewed, agreed and updated accordingly by key stakeholders/ meeting attendees, ensuring the monitoring of progress against action plans is highlighted as a core function. The updated fixed agenda should include a summary of outstanding Inspection Actions, ensuring regular discussion/ revisiting to enable action progression and overall accountability. Risk and Governance Lead Midwife to provide relevant information regarding outstanding Inspection Actions to inform MatNeo oversight group. This action is dependent upon the previous actions for Recommendation 2.1. Outstanding Inspection Actions should be presented during the MatNeo oversight group	Children & Women	31/03/2025	Amber	Overdue				

Maternity Care - Ockenden Review	Executive Nurse Director	19/08/2024	2.1 - The scope of the Maternity and Neonatal Oversight Group should be reviewed, and it should be ensured that the monitoring of progress against action plans is highlighted as a core function of the group. 2.2 - Regular status updates should be reported to the Quality, Safety and Experience Committee with respect to overall progress against implementing actions recommended by external reviews.	Corporate Governance - Internal Audit/2024/847/MD2/2	2.2 - The agenda for the Quality, Safety and Experience Committee meeting to be reviewed, agreed and updated accordingly by key stakeholders/ meeting attendees, to include the overall progress against implementing actions recommended by external reviews. Risk and Governance Lead Midwife to provide relevant information regarding outstanding Inspection Actions to inform the Quality, Safety and Experience Committee meeting discussion. This action is dependent upon the previous actions for Recommendation 2.2. Outstanding Inspection Actions should be presented during the Quality, Safety and Experience Committee meeting to further support Inspection Action completion and ensure further oversight. This action is dependent upon the previous actions for Recommendation 2.2.	Children & Women	31/03/2025	Green	Overdue				
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/MD3/1	3.1 - CAVUHB, as with all other health boards across Wales, are experiencing challenges within clinical coding workforce capacity. There is a National and local programme of work underway to address this. Whilst the programme of work progresses, review of procedure numbers will be reviewed against 4 months prior for any additions and process will be followed as per 4.3.	Clinical Diagnostics & Therapeutics	31/03/2025	Amber	Partially complete (Overdue)	04/02/2025		Clinical coding is a National Challenge and discussions are being held in National Value and Sustainable board.	August 2026 - as part Clinical Coding improvement programme, which includes incorporating Audit Wales recommendations, work force, performance and clinical engagement plans have been developed and are being delivered / enacted. Performance for 26/27 as measured against the WG KPI has shown marked improvement. March 2026 - action reopened from instruction by Joanna North. Agreed by Internal Audit. April 2025 - Action approved on behalf of the Executive Director of Public Health. March 2025 - The reason for data being changed has been identified as due to coding lags. **data change is due to coding lag** *as coding improves numbers of change will reduce** CAVUHB, as with all other health boards across Wales, are experiencing challenges within clinical coding workforce capacity. There is a National and local programme of work underway to address this. As the coding improves, the number of data changes will reduce.
Mortality Reviews	Executive Medical Director	24/04/2024	The Health Board should develop an overarching policy and procedure following completion and approval of the All-Wales Learning for Mortality Review Model Framework which sets out the respective roles and responsibilities and the procedures which should be followed.	Corporate Governance - Internal Audit/2024/750/MD1/1	Development of a learning from mortality framework.	Corporate Nursing	01/04/2025	Amber	Partially complete (Overdue)	20/05/2024			ME referrals discussed in pre-panel prior to Mortality Scrutiny panel and further actions - M&M/NRI/fact finding/thematic learning agreed. Learning considered at Learning from Mortality Safety Group where expectation of CB representatives is to take learning back to CB or Directorate level Q&S. Overarching policy to be described
LIMITED Follow Up: Implementation of Health Roster System	Executive Director of People and Culture / Executive Nursing Director	07/01/2025	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	Corporate Governance - Internal Audit/2025/257/MD4/1	Although the auto rostering feature has been made available for all areas, take up has been limited due to individual work life balance agreements not being up to date in the Health Roster system. CB Directors of Nursing will request all areas who are not using the auto roster feature to contact the E-Rostering team to ensure all WLB agreements are current and can therefore improve the capability of publishing usable rosters.	Corporate Nursing	01/04/2025	Amber	Overdue	04/02/2025			25/3/26- The E-rostering team have been working with managers to update current and approved work life balance agreements to allow for auto-rostering for staff who have this agreement. Ongoing work with managers will be required to encourage the use of the auto-rostering functionality within the HealthRoster system to form the fundemental element of rostering for teams.
Specialist Services Clinical Board Governance and Financial Management Arrangements	Chief Operating Officer	24/10/2024	1.1 - The Specialist Clinical Board should maintain oversight of key decision-making groups and governance forums and ensure that these are governed by approved Terms of Reference. 1.2 - The Specialist Services Clinical Board should also maintain records of Terms of Reference in place, their ownership and the required review dates to ensure a timely process for ToR review/update.	Corporate Governance - Internal Audit/2024/854/MD1/2	1.2 - The Terms of Reference for each of the decision-making groups will be stored in the Clinical Board Teams folder as above. In addition, to ensure consistency, the Clinical Board will ensure that the ToR for each of the groups will be reviewed annually at the first meeting at the start of the financial year.	Specialist Services	30/04/2025	Red	Overdue	05/11/2024			

Record Management	Director of Digital and Health Intelligence	06/05/2025	Some of the records storage areas lacked protection from water or fire which leads to a risk of loss of records.	Corporate Governance - Internal Audit/2025/989/MD2/1	1. Remove any obstacles to smoke detection equipment	Digital and Health Intelligence	20/05/2025	Red	Overdue	20/05/2025			August 2026 - obstacles have been removed. Areas of the departments estate continue to be susceptible to internal leaks - as highlighted in the a summary report by the Vice Chair on their recent visit to Health Records UHW. Workforce Inspections continue to highlight issues and remedial actions prioritised and where feasible, taken. The department frequent liaise with CEF, however, much of this is reactive and is not meeting the category levels for proactive work to be taken.
Record Management	Director of Digital and Health Intelligence	06/05/2025	There has been no disposal of records, as such the health board is retaining records longer than the agreed retention period. This includes both physical and electronic records.	Corporate Governance - Internal Audit/2025/989/MD4/2	2. Develop a destruction of medical records plan, with progress reviewed via the Clinical Information Programme.	Digital and Health Intelligence	31/05/2025	Red	Overdue	20/05/2025			August 2026 - through improvement work related to the Scanning Bureau section and supported by Shaping Change, and following liaison with the Information Governance and CD&T Clinical Board, the department has a robust destruction procedure (SOP) for medical records it has scanned. It has recently commenced destruction where the agreed procedure has been followed.
Record Management	Director of Digital and Health Intelligence	06/05/2025	Currently there is no formal plan to develop or implement an electronic health record within the health board.	Corporate Governance - Internal Audit/2025/989/MD5/1	1. Develop a programme plan to deliver full roll out of CIT to acute specialties, with progress reviewed via the Clinical Information Programme	Digital and Health Intelligence	31/05/2025	Red	Partially complete (Overdue)	31/07/2025			July 2026 - CIT roll out ongoing. >=85% compliance. Focused work in train with the dermatology speciality. Technical requirements / adaptations needed. This is being explored in liaison with Clinical Coding improvement plans.
LIMITED - Surgery Clinical Board - Consultant Job Plans Follow Up	Chief Operating Officer	05/03/2025	Orthopaedics and General Surgery - All job plans should be routinely reviewed and re-published every 12 months, even if there are no changes to the job plan.	Corporate Governance - Internal Audit/2025/689/MD7/1	We acknowledge that there is a need for the Clinical Board to improve its processes in this regard. Through the CD Forum and also a step change in the job planning process (referenced earlier) for job plans that have not changed we hope this matter will be resolved.	Surgical	31/05/2025	Red	Partially complete (Overdue)	20/05/2025			Our signed off Job Plans have significantly improved over the past year reaching mid eighties at peak. There is some deterioration to the seventies at present because Job Plans expire after 12 months. Several directorates are in the planning phase or are in the process of undertaking annual Job Planning meetings at present and we are confident that the numbers will improve shortly and that we should get to 90%. KM provided as with a document to guide directorates through rapid republication of Job Plans if no changes are made that need to be agreed.
Endoscopy Unit Investment (Advisory)	Chief Operating Officer / Executive Director of Finance	10/04/2025	In future, all project revenue expenditure over the required values, in line with the Health Board's scheme of delegation, should be approved by the Board and any significant changes to the expenditure should also be reported and approved accordingly. To aid this process for future projects, the Health Board should consider establishing a centralised live project register for projects over an agreed value and to provide updates to the Board. The register would map progress against key milestones and report on significant changes to plans and inherent risks.	Corporate Governance - Internal Audit/2025/991/MD1/1	• The Health Board will set up a centralized live project register for all projects exceeding an agreed value (for planned care projects this will sit in relevant clinical boards and be monitored through monthly tracking meetings but also report into the planned care board run by Cath Wood (Director of Planned Care). This register will map progress against key milestones, report on any significant changes to plans and highlight inherent risks (delays in implementation, financial discrepancies, impact of risks and mitigation) This will ensure that all project revenue expenditure will be reported and aligned to operational delivery. The planned care board will feed into the post implementation review via the Investment Group on a regular basis but also by exception if significant risks present. • Non-recurrent funding from Welsh Government is known to be a cause for concern in managing and developing recurrent service improvements and sustainable planning. Future approach will need to incorporate explicitly into the project register: a) Agreed organisational plan to fund longer term, identification of funding stream	Finance	30/06/2025	Green	Partially complete (Overdue)	30/05/2025			This has been agreed for the planned care forum and DCOO is the SRO and holds the governance associated with this action. The live registry will be monitored in the monthly planned care meeting and each of the key questions will be posed for all projects. Minutes and an action log will be taken to ensure the governance remains in place. The associate director of finance covering planned care will check each month to ensure compliance. If there are changes to financial quantum this will be taken through the new Value Realisation Group
Chemocare IT System Follow-up	Director of Digital and Health Intelligence	24/10/2023	System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.	Corporate Governance - Internal Audit/2023/302/MD1/1	Discussions are still ongoing, as there is a lack of clarity over where alerts should come from with the position being monitored via regular discussions with suppler and IT.	Digital and Health Intelligence	30/06/2025	Amber	Partially complete (Overdue)	07/11/2023			April 2025 - system managers receiving alerts for interface issues, although not able to automate. July 2024 IA tracker update - No update provided.

Endoscopy Unit Investment (Advisory)	Chief Operating Officer / Executive Director of Finance	10/04/2025	All key decisions and discussions should be recorded and evidenced within the BCAG meeting minutes and an action log should be produced to record and track all actions relating to the project. Members of the BCAG should attend the required meetings or send a representative when they are unable to attend. The project team should maintain a register of all project risks that is subject to regular review and updating and is reported to the BCAG.	Corporate Governance - Internal Audit/2025/991/MD2/1	BCAG has now been replaced by the Investment Group. All key decisions made within clinical board, planned care board or executives will be recorded and evidenced in the investment group moving forward through relevant minutes and actions. An action log will be produced to record and track actions relating to projects/investments. Senior Responsible officer (For Endoscopy JE, Deputy Director of Operations Medicine) will maintain a register of delivery risks, which will be subject to regular review and updated in regular agreed intervals through relevant board including relevant clinical board, planned care board and investment group.	Finance	30/06/2025	Green	Overdue	20/05/2025			
Endoscopy Unit Investment (Advisory)	Chief Operating Officer / Executive Director of Finance	10/04/2025	The Health Board should ensure that all future projects are managed in accordance with a standard operating procedure in order to strengthen the governance arrangements. This would improve assurance by reporting, tracking risks at key stage gates and help to consolidate project resources and present data.	Corporate Governance - Internal Audit/2025/991/MD3/1	• The Health Board will ensure future projects are managed in accordance with standard operating procedures. Having reviewed available documentation, it is clear there is a need to refresh documentation strengthening governance arrangements. These will include, tracking of delivery, tracking of risks and mitigation at key stages, consolidating project resources, clarity of accountability and responsibility through SRO function. • Development and utilisation of responsible accountable consulted and informed (RACI) table (already partially utilised in a number of projects across the organisation. The SOP will stipulate the need for this for projects over an agreed value. • Project team establish one project steering group with key stakeholders for major projects. Documentation is standardised and follows organisational templates. Both capital and review bids for one project are presented together to ensure transparency and risks are understood and reflected appropriately to support clear decision making.	Finance	30/06/2025	Green	Overdue	20/05/2025			
Record Management	Director of Digital and Health Intelligence	06/05/2025	Transportation of records across the health board is within unsealed containers, and we further noted a lack of tracking of records.	Corporate Governance - Internal Audit/2025/989/MD3/1	1. Update the UHB Transportation of Medical Records Procedure (IG)	Digital and Health Intelligence	30/06/2025	Amber	Overdue	20/05/2025			August 2026 - the procedure has yet to be updated
Record Management	Director of Digital and Health Intelligence	06/05/2025	Transportation of records across the health board is within unsealed containers, and we further noted a lack of tracking of records.	Corporate Governance - Internal Audit/2025/989/MD3/2	2. Once complete, distribute to all staff members and services, emphasising personal responsibilities for transporting, receiving and tracking of records - internally and externally - providing links to associated training packages & documentation	Digital and Health Intelligence	30/06/2025	Amber	Overdue	20/05/2025			August 2026 - the procedure has yet to be updated, as such it has not been distributed
Endoscopy Unit Investment (Advisory)	Chief Operating Officer / Executive Director of Finance	10/04/2025	The Health Board should carry out a detailed review and assessment of the future plans for Endoscopy provision to ensure that the capital and revenue investments that have already been made are effectively utilised to enable achievement of the project's key aims.	Corporate Governance - Internal Audit/2025/991/MD4/1	• The Health Board under the auspices of the medicine clinical board have started to carry out a detailed review and assessment of future plans for endoscopy provision with an agreed timeline for delivery. • There is also a review of the revenue investments already made, clearly evidencing as per this audit report the way in which resource has been deployed and what has been delivered. The focus is now on driving a plan that delivers a realistic effective and efficient, sustainable service within an agreed timeline, including the utilisation of the LHP. • Further work is being undertaken including an establishment review for endoscopy that encompasses the full resources available for the endoscopy service, how they are being deployed, what is currently being delivered, against expected activity including productivity and efficient gains aligned to GIRFT and JAG. This will also form part of the MCB QIEP.	Finance	30/06/2025	Green	Overdue	20/05/2025			

Record Management	Director of Digital and Health Intelligence	06/05/2025	There has been no disposal of records, as such the health board is retaining records longer than the agreed retention period. This includes both physical and electronic records.	Corporate Governance - Internal Audit/2025/989/MD4/1	1. Update the Records Management Retention and Destruction Protocol and Schedule to include specific guidance related to the UHB's agreed local instruction on disposal (IG)	Digital and Health Intelligence	30/06/2025	Red	Overdue	20/05/2025			August 2026 - the protocol has yet to be updated
Endoscopy Unit Investment (Advisory)	Chief Operating Officer / Executive Director of Finance	10/04/2025	There is an opportunity to improve governance and communications by adding a Responsible, Accountable, Consulted and Informed (RACI) table for Committees and other forums to ensure decisions are shared with all affected parties enabling the retention of auditable communication trails.	Corporate Governance - Internal Audit/2025/991/MD5/1	• The Health Board will improve governance and communication by adding a RACU table for the relevant governance structure and committees. This will ensure that decisions are shared and made in the correct forum aligned to organisational policy. The capturing and retention of auditable communication trails is critical and will support good governance and facilitate improved learning. • In additional each project/development will have a single overarching person designated as senior responsible officer to consolidate and track risks and issues associated with progress.	Finance	30/06/2025	Green	Overdue	20/05/2025			
Legal Services - ADVISORY	Director of Corporate Governance	18/12/2024	The Corporate Governance Team should engage with central finance team to obtain financial spend reports that encompass the legal service spend for the whole Health Board.	Corporate Governance - Internal Audit/2024/835/MD6/1	Request quarterly updates from Finance to cross reference corporate governance expenditure on legal spend and what has been billed in Finance.	Corporate Governance	30/06/2025	Green	Partially complete (Overdue)	04/02/2025			All electronic forms have been created and available for COP, Commercial and Inquest. COP and Commercial are being actively used. June 2025 update - AP to pick this up with the Finance Ops Manager later in the year. Work has been done to strengthen the oversight of legal spend with Legal & Risk from a complex patient perspective and work is ongoing to look at Commercial legal advice requests & inquests monitoring and discussions are underway to explore embedding a electronic instruction form for these areas like is in place for complex patient requests. August 2026 update - evidence of checking the legal spend with finance needs to be reflected in this action record. re-assigned action to Andrew to complete this as person who signs off legal invoices and has oversight of legal spend which correlates to the electronic instruction forms which have now been set up.
Therapies and Health Sciences - Agency, Additional Hours and Overtime	Executive Director of Therapies & Health Science	21/01/2025	Staffing Establishments - There are discrepancies between the WTE on the budget report and the Staff in post list across three out of the five departments reviewed, for instance: • Audiology department showed an over-establishment of 3.81 WTE, which is due to Trainee positions. These are being offset against other vacancies in the department. • Cardiac Physiology department had 6.59 WTE Band 6 vacancies which are offset against three Band 7 posts, which are a current cost pressure. • Respiratory Physiology department WTE was incorrect and had an overspend of £6k in month due to unprocessed cross Charges of a 0.26 WTE Band 8a by Finance to other organisations.	Corporate Governance - Internal Audit/2025/947/MD1/1	Audiology, Cardiac Physiology and Respiratory Physiology departments will organise regular Finance Business Partner meetings to discuss budget allocation and WTE. Departments to run through vacancy tracker and actions. Finance Business Partners will communicate specific budget summaries showing current allocation. Professional and Operational leads will track decisions using decision and risk log to understand agreed WTE and budget allocations on standardised spreadsheet across departments. Audiology, Cardiac Physiology and Respiratory Physiology departments will undertake regular monthly monitoring of WTE figures to compare budgeted and actual WTE figures. Action logs updated where identified discrepancies have been identified, and steps undertaken to resolve WTE with timeline and responsible partner. Services to utilise People and Culture and finance dashboards to track WTE position with automated flags on discrepancies identified. All notes to be recorded on action log and discrepancies to be actioned appropriately.	Clinical Diagnostics & Therapeutics	01/07/2025	Amber	Overdue	02/09/2025			

Record Management	Director of Digital and Health Intelligence	06/05/2025	There is a lack of guidance for services who manage their own records.	Corporate Governance - Internal Audit/2025/989/MD1/1	1. Update the UHB's Records Management Policy and Procedures (IG)	Digital and Health Intelligence	31/07/2025	Amber	Overdue	20/05/2025	Services are relying upon out of date guidance to support records management		The existing policies and guidance are out of date and need to be reviewed. They are currently owned by the Information Governance Department but Information Governance doesn't own records management nor has the expertise to write a policy on behalf of the organisation. There clearly needs to be IG involvement. There needs to be a discussion with Medical Records and Corporate Governance about where this policy/guidance should sit.
Surgery Clinical Board Governance and Financial Management Arrangements	Chief Operating Officer	30/09/2024	Directorate Meetings - Directorate meetings generally mirror those set up at Clinical Board level. We reviewed the meetings' structure and supporting documentation for four directorates. The General Surgery Directorate failed to respond to our requests for information, despite the request being escalated to the Director of Operational Planning & Performance. A ToR was not available for the key meetings such as the monthly directorate meetings and clinical governance meetings. Whilst many of the meetings were summarised in e-mails, meeting notes / minutes and action logs were not generally being produced. We note that some Directorates have started using Co-Pilot software to produce meeting notes, but these did not include the names of the attendees.	Corporate Governance - Internal Audit/2024/855/MD2/1	Directorates are currently being provided with details of revised governance arrangements for all meetings in Surgery, with up to-date TOR, so as to clarify the requirements for attendance and purpose of meetings at both Directorate and Clinical Board Level. This will also include the requirement for noting actions and managing action logs going forward. Meeting notes will contain details of attendees too.	Surgical	31/07/2025	Amber	Partially complete (Overdue)	02/09/2025			Directorates have been provided with TOR for their directorate meetings and a framework agenda (see attachments). DOO requested to check that managers are using the documents. Managers have been requested to ensure completion of attendance list and action log as part of meetings. Efforts are being made to locate a formal TOR for Clinical Governance Meetings as these should be standard across the UHB
Record Management	Director of Digital and Health Intelligence	06/05/2025	Transportation of records across the health board is within unsealed containers, and we further noted a lack of tracking of records.	Corporate Governance - Internal Audit/2025/989/MD3/3	3. Regular audits for all services, monitoring levels of transport and tracking adherence, with results shared with Clinical Boards and relevant UHB groups (relevant Heads of Service)	Digital and Health Intelligence	31/07/2025	Amber	Overdue	20/05/2025			August 2026 - the related procedure has yet to be updated
LIMITED - Local Data Repository	Director of Digital and Health Intelligence	17/04/2025	We note that currently the OpenStack environment is hosted on servers within the services accommodation centre (SAC). Although this is spread across the two rooms this provides no geographical resilience and reduces the benefits associated with hosting a private cloud.	Corporate Governance - Internal Audit/2025/990/MD5/1	Establish a specific infrastructure project to underpin the LDR service. Ensure the infrastructure solution adheres to existing national and corporate standards, provides a mature management capability (which aligns to the All Wales Target Operating Model (TOM)) and minimises risk of technical debt by aligning to the Digital Foundations Programme.	Digital and Health Intelligence	31/07/2025	Amber	Overdue	20/05/2025			
Record Management	Director of Digital and Health Intelligence	06/05/2025	Currently there is no formal plan to develop or implement an electronic health record within the health board.	Corporate Governance - Internal Audit/2025/989/MD5/2	2. Share the progress being made with the Digital Foundations investment case relating to the UHB's electronic patient record (EPR) plan	Digital and Health Intelligence	31/07/2025	Red	Overdue	20/05/2025			
LIMITED - Local Data Repository	Director of Digital and Health Intelligence	17/04/2025	There is no documented evidence of approval of the LDRs open source approach, or of formal sign off of design, specifications, decisions or security review.	Corporate Governance - Internal Audit/2025/990/MD6/1	Define a comprehensive list of governance artefacts that will be included within a formal programme delivery capability.	Digital and Health Intelligence	31/07/2025	Amber	Overdue	20/05/2025			
Therapies and Health Sciences - Agency, Additional Hours and Overtime	Executive Director of Therapies & Health Science	21/01/2025	Agency Shifts paid above the rate card. Three of the five areas reviewed used agency locum cover. Two of these three areas paid above the rate card. In October, there were 20 Agency Locum shifts worked in Cardiac Physiology, all of which were at Band 6. The standard capped rate for Band 6 is £32 per hour. • 20/20 shifts were paid above the rate card. • 3/20 shifts were worked by the same person who was paid 53% above the rate card. In addition, all 13 Agency Locum shifts worked in Respiratory Physiology in June 2024 were above the approved Band 6 rate card. There was no distinct agreement or challenge regarding the elevated rate, nor was this specified on the Agency approval form. There were three instances (two agency forms related to Cardiac Physiology and	Corporate Governance - Internal Audit/2025/947/MD5/1	Cardiac Physiology and Respiratory Physiology will amend the agency approval form with a requesting officer and approving officer roles. Once changed, departments to communicate through internal communications and meetings. Cardiac Physiology and Respiratory Physiology will adopt copies of medical staff agency request form and review impact of new form on reducing overpayments every 3 months. Cardiac Physiology and Respiratory Physiology will ensure all agency requests are authorised by the Executive Director for AHPS and Health Science or a delegated deputy.	Clinical Diagnostics & Therapeutics	01/08/2025	Amber	Overdue	02/09/2025			

Therapies and Health Sciences - Agency, Additional Hours and Overtime	Executive Director of Therapies & Health Science	21/01/2025	Status of Vacant posts: All departments reviewed are operating with vacant posts and are therefore requesting agency, bank, additional hours, and overtime to cover these posts. However, tracking these vacancies back to the TRAC system and reconciling them with the additional hours worked has proved challenging. For instance, there was a Band 6 vacant post in Cardiac Physiology, but the last job advert was advertised in April 2024, and we were further informed that Band 5 job adverts go out annually but there was no evidence to support this. Genomics is working to determine their true vacancy factor due to the complexity and growing volume of genomic testing but have yet to ascertain the exact vacancy figure. At the time of the audit, there were no vacancies on TRAC for Genomics. However, the department was able to share their 'Submitting Vacancy for Approval to TRAC' SOP, which no other department has in place.	Corporate Governance - Internal Audit/2025/947/MD2/1	Audiology, Cardiac Physiology, Genomics, Phlebotomy and Respiratory Physiology departments will track all vacancies using a vacancy tracker with current vacancies, status updates, timelines, difficulty to fill, and reasons for delayed recruitment process. Posts that are difficult to fill will need recruitment strategies/plans and liaise with the relevant People and Culture support. Update SOP and internal guidelines on timeframes for updating TRAC system. Regular monthly monitoring of date and time of vacancy posting and any delays between approval and posting arrangements. Exception reports to be directed to team and recorded where breaches are apparent and corrective action taken in line with recommendation.	Clinical Diagnostics & Therapeutics	08/08/2025	Amber	Overdue	02/09/2025			
Record Management	Director of Digital and Health Intelligence	06/05/2025	There is a lack of guidance for services who manage their own records.	Corporate Governance - Internal Audit/2025/989/MD1/2	2. Update Medical Records' Standard Operating Procedures (SOPs) accordingly and in respect of the above (Head of Health Records)	Digital and Health Intelligence	31/08/2025	Amber	Overdue	20/05/2025		
LIMITED - Cyber Security	Director of Digital and Health Intelligence	15/08/2025	Lack of minutes for the Cyber Security Sub-group - While risk assessments completed by the Cyber Security SubGroup record decisions and advice provided, there are no formal minutes or records of the group's meetings. Given the group's role in reviewing the cyber risk register, assessing critical systems and subsequently providing assurance and advice to the SIRO and CCIO to make decisions, as well providing assurance to the Digital and Infrastructure Committee (as outlined in the ToR for the group), the absence of minutes for the meeting limits transparency and weakens governance. Introducing formal minutes or meeting notes would strengthen oversight and ensure a complete audit trail of discussions and decisions.	Corporate Governance - Internal Audit/2025/1047/MD5/1	Although an Action Log is maintained we will ensure that future meetings are recorded and transcriptions made available so that an accurate record of the meeting is recorded.	Digital and Health Intelligence	31/08/2025	Amber	Overdue	02/09/2025		
Therapies and Health Sciences - Agency, Additional Hours and Overtime	Executive Director of Therapies & Health Science	21/01/2025	Insufficient documented evidence to support approval prior to shift being worked. Issues were identified regarding the approval and documentation of bank and overtime/additional hours prior to being worked. In Cardiac Physiology, obtaining supporting documentation was challenging, particularly when reasons were communicated verbally. Verifying shift dates against approval dates proved difficult due to varied methods across departments, for example Cardiac Physiology and Respiratory Physiology do not show the hours worked on the rota. In addition, we were unable to verify the grade of the post for which the cover is required. Whereas most areas lacked a recorded procedure, Genomics had produced documentation. There were six instances within Cardiac Physiology, whereby actual agency hours worked exceeded approved hours, with insufficient documentation to support	Corporate Governance - Internal Audit/2025/947/MD4/1	Cardiac Physiology and Respiratory Physiology will create an SOP for the process for pre-approval of additional hours, including required documentation and approval hierarchy (e.g. written approval before hours are worked, specific dates and hours worked, justification for the additional hours, required staff grade, TRAC reference number if covering a vacancy). To be disseminated across team through internal communications and team meetings. Departments to record meeting minutes and update logs. Departments to monitor reports showing additional hours worked and action noncompliance. Cardiac Physiology and Respiratory Physiology will assess the current manual rota system including identification of risks, inefficiencies and gaps in recorded hours worked. Department will transition to Health Roster to improve verification of work being performed; ensure the services are on the roll out plan for Health Roster aiming to be onboarded within the next 18 months.	Clinical Diagnostics & Therapeutics	01/09/2025	Amber	Overdue	02/09/2025		

Therapies and Health Sciences - Agency, Additional Hours and Overtime	Executive Director of Therapies & Health Science	21/01/2025	Verification of hours prior to payment. Testing the process for verifying hours worked before payment, particularly for those that are manually processed and included in the Pay Return, has proven to be challenging due to the insufficient information displayed on the rota. Furthermore, enquiries revealed that in some departments, a reconciliation with the rota to confirm that these hours were indeed worked prior to being entered into the pay return was not consistently applied. For instance, on the Cardiac Physiology rota, only the name of the person working the shift is identified therefore confirming if the 12 hours of overtime were verified as having been worked before being paid was not possible.	Corporate Governance - Internal Audit/2025/947/MD6/1	Audiology, Cardiac Physiology, Genomics, Phlebotomy and Respiratory Physiology departments will create an SOP outlining the process for requesting and approving additional hours, verification steps to confirm work was performed, requirements for break deductions in line with policy and legislation. Audiology, Cardiac Physiology, Genomics, Phlebotomy and Respiratory Physiology departments to standardise manual timesheet or approval form in the meantime while work towards Health Roster. Department will transition to Health Roster to improve verification of work being performed; ensure the services are on the roll out plan for Health Roster aiming to be onboarded within the next 18 months.	Clinical Diagnostics & Therapeutics	01/09/2025	Amber	Overdue	02/09/2025			
Waiting List Management	Chief Operating Officer	04/08/2025	Prioritisation methodologies - Sample testing and discussions with key leads across our sampled service areas identified the Health Board continues to use the Royal College of Surgeons (RCS) clinical prioritisation matrix, a framework introduced during the COVID-19 pandemic. While this model was appropriate during emergency response phases, its ongoing use alongside the traditional Urgent/Routine classification may now be skewing waiting list management. For example, a patient previously categorised as Priority 3 under the RCS matrix could be overtaken by a newly referred Priority 2 patient—despite both being considered 'routine' under the standard model—potentially disrupting the fairness of the "treat in turn" principle. Although no breaches were identified in our audit testing, this dual system presents a risk of inconsistent prioritisation and scheduling.	Corporate Governance - Internal Audit/2025/853/MD2/1	The Health Board will standardise the use of patient prioritisation frameworks across all service areas or clearly define how multiple systems should be applied in practice, to ensure consistency in scheduling and safeguard the integrity of the "treat in turn" approach.	Operations	30/09/2025	Amber	Overdue	02/09/2025			
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.	Corporate Governance	30/09/2025	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

Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	To undertake an initiative to enhance the inventory of hosted servers by: 2.1 - Updating the inventory to include detailed mappings of each server to the specific applications, services, and functions it supports. This will provide a comprehensive view of the technical environment, helping to identify critical systems and reduce the risk of data silos. It will also aid in better management and oversight of the systems and their interdependencies. 2.2 - Implementing a process to create and maintain detailed data flow diagrams that track the movement of data across systems. These diagrams should illustrate how data is transferred, processed, and stored across various servers and applications, highlighting potential vulnerabilities or bottlenecks in data handling. This will improve transparency and facilitate better decision-making regarding data management, security, and system integrations. 2.3 - Establishing a routine process to	Corporate Governance - Internal Audit/2025/995/MD2/1	2.1 - We fully agree with this suggestion. To achieve this, the Health Board will expand our ongoing project to develop an advanced digital solution (Power App), originally intended to improve the accuracy and completeness of Information Asset Registers (IARs). Specifically, this initiative will include comprehensive mappings of all hosted servers to the applications, services, and functions they support. This enhanced visibility will facilitate clearer identification of critical systems, clarify interdependencies, reduce data silos, and strengthen overall data governance.	Digital and Health Intelligence	30/09/2025	Green	Overdue	20/05/2025			
Record Management	Director of Digital and Health Intelligence	06/05/2025	Some of the records storage areas lacked protection from water or fire which leads to a risk of loss of records.	Corporate Governance - Internal Audit/2025/989/MD2/2	2. Agree an estates plan to address identified issues including provision of alternative accommodation where remedial actions are not deemed feasible	Digital and Health Intelligence	30/09/2025	Red	Overdue	20/05/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	To undertake an initiative to enhance the inventory of hosted servers by: 2.1 - Updating the inventory to include detailed mappings of each server to the specific applications, services, and functions it supports. This will provide a comprehensive view of the technical environment, helping to identify critical systems and reduce the risk of data silos. It will also aid in better management and oversight of the systems and their interdependencies. 2.2 - Implementing a process to create and maintain detailed data flow diagrams that track the movement of data across systems. These diagrams should illustrate how data is transferred, processed, and stored across various servers and applications, highlighting potential vulnerabilities or bottlenecks in data handling. This will improve transparency and facilitate better decision-making regarding data management, security, and system integrations. 2.3 - Establishing a routine process to	Corporate Governance - Internal Audit/2025/995/MD2/3	2.3 - Responsibility for ensuring mapping, data flows and data catalogues are accurate and up to date will be the responsibility of a new "Data steering group" (DSG) - see below (opportunity 4) – and the existing "Technical Design Authority in relation to standards. The DSG will act to 'commission' changes to existing data flows and publication of 'data products'. We will leverage existing plans for a Change Advisory Board (CAB) that will include tracking and approving changes to the LDR programme and supporting infrastructure, reflecting improvements in the organisation's change management processes in reducing the untoward impact of change across applications, systems and data products.	Digital and Health Intelligence	30/09/2025	Green	Overdue	20/05/2025			
LIMITED - Surgery Clinical Board - Consultant Job Plans Follow Up	Chief Operating Officer	05/03/2025	Orthopaedics and General Surgery - All job plans should include Clinical Board (service outcomes) and they should be subject to an annual assessment.	Corporate Governance - Internal Audit/2025/689/MD3/1	We acknowledge that there is a gap in this area. However since the last review the Clinical Board has appointed a new Clinical Board Director and the Triumvirate is working towards agreeing service outcomes with all specialties. These outcomes will be documented going forward.	Surgical	30/09/2025	Amber	Partially complete (Overdue)	20/05/2025			Job Planning over the past year was focussed on DCC sessions to be delivered in clinics, theatre and during on calls as well as SPA. There are generic outcomes documented and agreed on, but specific agreed outcomes are not captured on Allocate in its current form. There is no clear place on Allocate to document agreed templates other than in an attached note. LJ in general surgery has an advanced system for monitoring DCC output which is shared with clinicians. Clinicians does not always accept that the data presented to them is accurate. Emphasis is being put on clinicians ensure that the data regarding their clinical activity is accurate. SOC previously worked in General surgery and is planning to adopt the same monitoring in T&O this year. Important to note that currently theatre activity is only measure in sessions delivered, but peri-op is currently working towards improving efficiency in theatre where directorate and individual surgeons data will be assessed and shared. An electronic rostering system like CLW used in

Waiting List Management	Chief Operating Officer	04/08/2025	Data quality feedback loop/Lessons Learnt - The central validation team plays a critical role in identifying and correcting errors in waiting list data submitted by service areas. While the team is aware of recurring issues—such as incorrect RTT clock starts, misclassification of patient priority, and incomplete pathway information—there is currently no formal mechanism for reporting these trends or sharing lessons learned across specialties. The absence of structured feedback loops limits the Health Board's ability to drive consistency, reduce repeat errors, and improve the overall quality of waiting list data. Although we have sighted evidence of waiting list validation taking place, the opportunity to use this intelligence to inform training, improve data entry practices, and strengthen local validation processes is not being fully realised. This gap is particularly relevant given the scale of the waiting list challenge and the reliance on accurate data to support prioritisation, performance reporting, and patient safety.	Corporate Governance - Internal Audit/2025/853/MD3/1	The Health Board will develop a structured reporting mechanism within the central validation function to capture, analyse, and disseminate common validation errors and data quality issues identified during routine checks. This should include: • A quarterly summary report of recurring validation issues by specialty; • Thematic analysis to identify root causes and trends; • Targeted feedback to service areas with recommendations for improvement; and • Integration of findings into training and guidance materials for local validation teams This approach would support a culture of continuous improvement, enhance data quality, and strengthen the Health Board's ability to manage waiting lists effectively and equitably.	Operations	30/09/2025	Amber	Overdue	02/09/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	3.1 - Implement a data governance framework that outlines how external engagements are tracked, ensuring that all interactions are properly documented and monitored. This could include creating a central repository for meeting notes, decisions, and action items that are shared across the Health Board. 3.2 - Develop formal training for all Health Board representatives to include data governance, compliance, and ethical decision-making to ensure they manage data responsibly and align with organisational goals in external engagements. Training on communication, data interpretation, and relationship management will help maintain consistency and build strong partnerships. Proficiency in digital tools and risk management will further enhance their effectiveness and reduce potential risks. 3.3 - Set up a dedicated internal Microsoft Teams channel for all Health Board representatives. This channel would serve as a centralised platform for sharing	Corporate Governance - Internal Audit/2025/995/MD3/3	3.3 - We agree and such an approach makes use of existing investments such as those within the Microsoft 365 platform such as Teams and SharePoint. We will supplement this with the use of existing communication channels such as the 'Health Informatics Forum' to raise the profile of digital and data, and the quality agenda underpinning both.	Digital and Health Intelligence	30/09/2025	Green	Overdue	20/05/2025			
Waiting List Management	Chief Operating Officer	04/08/2025	Waiting Well Support Service remit expansion - The Waiting Well Support Service (WWSS) at the Health Board was launched in October 2024 as a proactive initiative to support patients experiencing long waits for elective care. While the service has made commendable progress in establishing a structured communication and support model, its current scope is limited to a small number of specialties—namely General Surgery (hernia and gall bladder), Orthopaedics (hip replacements), and more recently, total knee replacements. Discussions with the WWSS team confirmed that this limited coverage is due to capacity constraints and the sheer volume of patients on waiting lists. Plans are in place to expand the service to other high-demand areas, such as spinal surgery and gynaecology, but these have not yet been implemented.	Corporate Governance - Internal Audit/2025/853/MD4/1	The Health Board will prioritise a phased expansion of the WWSS, beginning with specialties that have the longest waiting times and highest clinical risk—such as spinal surgery and ophthalmology. This should be supported by a resource plan to ensure adequate staffing and digital infrastructure. A benefits realisation framework should also be developed to evaluate the impact of the expanded service and inform future scaling.	Operations	30/09/2025	Amber	Overdue	02/09/2025			

LIMITED - Surgery Clinical Board - Consultant Job Plans Follow Up	Chief Operating Officer	05/03/2025	Orthopaedics and General Surgery - Directorate management should ensure that all Consultant job plans include personal outcomes and service (Clinical Board) outcomes, and that personal outcomes are linked to service outcomes.	Corporate Governance - Internal Audit/2025/689/MD5/1	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. A Clinical Board time out session is planned for May 2025 with the intention of reviewing our annual planning process and ensuring personal and service outcomes are better linked.	Surgical	30/09/2025	Red	Partially complete (Overdue)	20/05/2025			Job Planning over the past year was focussed on DCC sessions to be delivered in clinics, theatre and during on calls as well as SPA. There are generic outcomes documented and agreed on, but specific agreed outcomes are not captured on Allocate in its current form. There is no clear place on Allocate to document agreed templates other than in an attached note. LI in general surgery has an advanced system for monitoring DCC output which is shared with clinicians. Clinicians does not always accept that the data presented to them is accurate. Emphasis is being put on clinicians ensure that the data regarding their clinical activity is accurate. SOC previously worked in General surgery and is planning to adopt the same monitoring in T&O this year. Important to note that currently theatre activity is only measure in sessions delivered, but peri-op is currently working towards improving efficiency in theatre where directorate and individual surgeons data will be assessed and shared. An electronic rostering system like CLW used in
Therapies and Health Sciences - Agency, Additional Hours and Overtime	Executive Director of Therapies & Health Science	21/01/2025	Incomplete Agency Request Forms We reviewed the Agency Request forms and found that all seven forms for Cardiac Physiology did not record the TRAC number associated with the vacancy on the form. Instead, 'Several' was stated in this section of the form. Additionally, there was an error in the TRAC reference on the Agency Request form for Respiratory Physiology. When the correct TRAC number was provided, it was discovered that the period covered by the TRAC number extended beyond the appointment date of the position, indicating that the post had been filled, and the TRAC number was no longer valid.	Corporate Governance - Internal Audit/2025/947/MD3/1	Cardiac Physiology to create project plan on the redesign process with roles and responsibilities established, actions, decisions and minutes recorded regarding design and control features. Departments will monitor iterative changes and version history and ensure alignment to medical agency request format using RAID logs. Formal approval from HR, finance and Clinical leads. Cardiac Physiology to include mandatory field for TRAC reference number. Department leads to communicate with staff by email and intranet posts that the TRAC reference number is to update accordingly and attainment to be monitored on monthly basis.	Clinical Diagnostics & Therapeutics	01/10/2025	Amber	Overdue	02/09/2025			
Core Financial Systems (Treasury Management) Jan 2023	Executive Director of Finance	20/01/2023	The Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure should be strengthened as follows: - The requirements of the Standing Financial Instructions, section 7.3.1 (d) Banking Procedures should be addressed; - Consideration of developing, if not included within the FCP, a separate procedure to cover the access and control arrangements of the online banking system, Bankline; and - To enhance resilience, the inclusion of the process for developing the monthly cashflow forecast, which is a key document used to inform Welsh Government on a monthly basis of the Health Board's cash requirements.	Corporate Governance - Internal Audit/2023/278/MD1/1	- Agreed to revise FCP to include the requirements of 7.3.1 (d) also addressed in point 2 on management actions. - Agreed FCP to be updated to include control arrangements for access, inputting and authorisation of the online banking system. - Agreed to update the process document for developing the monthly cashflow	Finance	31/10/2025	Amber	Partially complete (Overdue)	07/02/2023			Action points 1 & 2 have been completed in full. Point 3 - Monthly Cashflow - The FCP has been updated to address the points outlined in the internal report. The department has commenced a review of the cashflow process; it has become apparent that this review is quite extensive, taking into account the modernisation agenda and priority areas for improvement in the current system. Therefore, taking all these factors into account, it has been identified that cashflow modernisation/ review will be an ongoing process for the remainder of this financial year. An interim SOP has been developed as of April 2024, while the cashflow review is ongoing. The cashflow review will recommence post yearend, July 2024. July 2024 - The new "monthly cashflow" model is currently being parallel run for 3 months, alongside the existing (historical) cashflow process. The trial period shall run until 31.10.24, if successful, the changes shall be adopted, and the SOP shall be written by the end of November 2024. April 2025 - The cashflow forecast has been updated as of April 2025 with a new daily cashflow format, we also updated the MMR SOP

LIMITED - Interventions Not Normally Undertaken (INNU)	Executive Director of Public Health	03/12/2024	1.1 - A complete set of Hospital Health Pathways should be developed and added to the Hospital Health Pathways Portal to aid consistent application of the INNU policy. 1.2 - Following completion of the Health Technology Wales Review, the Health Board should incorporate the Welsh Government (WG) INNU guidance dated 25 August 2023 into its policy or engage with WG if clinicians have concerns. 1.3 - Clinical codes (where available) should be put in place for all interventions to enable identification, categorisation and monitoring to be undertaken.	Corporate Governance - Internal Audit/2024/926/MD1/1	1.1 - Community HealthPathways is in place and actions from the review following the notification from WG is due for completion Q4 24/25. There is an ambition to upload guidance onto the Hospital HealthPathways platform to support secondary care clinicians with patient management in line with the INNU policy. This is due for completion ~Q3 25/26 depending on other project priorities. As Community HealthPathways is the most impactful platform to support patient management we feel these timelines are appropriate to respond to the matter arising.	Public Health	31/10/2025	Red	Partially complete (Overdue)	04/02/2025			March 2026 - action reopened from instruction by Joanna North. Agreed with Internal Audit. April 2025 - Action approved on behalf the Executive Director for Public Health. March 2025 - Community HealthPathways is the most impactful platform to support patient management and appropriate INNU interventions have a pathway within the platform for CAVUHB. There is an ambition to upload guidance onto the Hospital HealthPathways platform to support secondary care clinicians with patient management in line with the INNU policy. The project team has priority pathways currently in their workplan and will consider when it will be possible to add appropriate INNUs to the platform.
Record Management	Director of Digital and Health Intelligence	06/05/2025	There is a lack of guidance for services who manage their own records.	Corporate Governance - Internal Audit/2025/989/MD1/3	3. Share SOPs with other services storing health records in order to adapt for specific local requirements and use accordingly (relevant Heads of Service)	Digital and Health Intelligence	31/10/2025	Amber	Overdue	20/05/2025			
LIMITED - Cyber Security	Director of Digital and Health Intelligence	15/08/2025	Inconsistent cyber security risk awareness across the organisation - Responses to our questionnaire showed that there is a disparity in cyber security awareness and oversight between the Board and Clinical Board Management Teams. Whilst Board members and Executive leadership receive regular updates on cyber security risks and incidents, are aware of mitigation actions and have seen the cyber risk on the Corporate Risk Register - Clinical Board Management Teams do not appear to receive the same level of information. This inconsistency suggests a communication gap that may hinder the Clinical Boards' ability to effectively understand and respond to cyber security threats, and with devolved responsibility for IT in the organisation this poses a risk. It is recognised that the Cyber Security Team have a dedicated SharePoint page that provides advice and updates, however more targeted updates may be required to the Clinical Boards and wider services.	Corporate Governance - Internal Audit/2025/1047/MD2/1	Engagement with the Clinical Boards management will be implemented via the Strategic Leadership Team (SLT) initially, to raise awareness and provide information on what each CB management team should be sharing in identifying and logging any cyber related risks. This is especially important where shadow IT arrangements exist. We will ensure that Cyber have visibility of CB risks, and vice versa for any other relevant risks.	Digital and Health Intelligence	31/10/2025	Red	Overdue	02/09/2025			
Chemocare IT System Follow-up	Director of Digital and Health Intelligence	24/10/2023	Finalise the review of the BCP.	Corporate Governance - Internal Audit/2023/302/MD2/1	Agreed. The BCP will be completed.	Digital and Health Intelligence	31/10/2025	Amber	Overdue	07/11/2023			April 2025 - there is a BCP in place, but it is being redone at present due to additional functionality being introduced. July 2024 IA tracker update - No update provided.
Medicine Clinical Board – Acute Medicine Model	Chief Operating Officer	20/08/2025	Medical staffing records - Weekly medical staffing records were observed to be maintained, but it was reported that copies are not retained and therefore historical medical staffing details cannot be readily determined. In consideration of the ongoing staffing shortfalls, the inability to refer to historical staffing data represents a significant control weakness. Management have reported that there are occasions where some discretionary services are not available due to staffing shortages, but it has not been possible due to the lack of historical staffing data to ascertain the extent or frequency of these occurrences. We are therefore unable to provide any assurance that medical staffing levels are appropriate to ensure effective delivery of all services as we were not provided with copies of staffing records.	Corporate Governance - Internal Audit/2025/1037/MD1/1	Copies of weekly medical staffing records will be retained.	Medicine	30/11/2025	Red	Overdue	02/09/2025			

Medicine Clinical Board – Acute Medicine Model	Chief Operating Officer	20/08/2025	Operational pressures on management - At the time of audit, it was reported that the Acute Medicine management team were experiencing significant operational pressures which did not appear to dissipate. It is not clear if this has been reported appropriately or if any remedial actions have been proposed.	Corporate Governance - Internal Audit/2025/1037/MD2/1	The ongoing operational pressures experienced by the Acute Medicine management team will be reported in the Emergency and Acute Medicine Directorate Performance Reports.	Medicine	30/11/2025	Amber	Overdue	02/09/2025			
Medicine Clinical Board – Acute Medicine Model	Chief Operating Officer	20/08/2025	Documentation of action plans - Documentation was not provided to adequately demonstrate that action plans are completed in relation to identified shortcomings. It was not possible to determine the means by which action plans may be produced, by whom, or if suitable review and update processes are in place.As the Health Board's performance in the Society for Acute Medicine Benchmarking Audit was noted as below average, it would be expected that an action plan be produced in response to this, and be subject to ongoing scrutiny, but no evidence was forthcoming to demonstrate that this had taken place.	Corporate Governance - Internal Audit/2025/1037/MD3/1	A summary of the content and details of the progress against relevant action plans will be reported in the Emergency and Acute Medicine Directorate Performance Reports.	Medicine	30/11/2025	Red	Overdue	02/09/2025			
LIMITED - Cyber Security	Director of Digital and Health Intelligence	15/08/2025	Cyber security risk management across the Clinical Boards - Responses to our questionnaire and follow-up communications highlighted a gap in cyber risk management within the Clinical Boards. Although these teams are responsible for their own IT systems, they are not consistently identifying, assessing or managing their own cyber security risks. While there is a centralised cyber security structure within the organisation that is headed up by the Cyber Security Team; there is devolved IT responsibility. So, while the Cyber Security Team manages the cyber security risk register, this will only include risks that they are directly aware of. However, Clinical Boards do not currently record cyber security risks on their local risk registers, despite being responsible for managing their own IT systems. As such cyber risks within Clinical Boards may not be appropriately identified, monitored or reported.	Corporate Governance - Internal Audit/2025/1047/MD3/1	Engagement with Clinical Boards management teams, initially via the SLT to raise awareness and agree a process for identifying and capturing local cyber or IT security risks in a consistent manner and that that CB service leads fully understand and own these risks. These cyber risks will be monitored centrally via AMaT to ensure that they are managed appropriately and owned by the CBs and the SIRO can take assurance that such risks are fully identified and assessed. Cyber risk ownership policy will need to support CBs help understand roles and responsibilities.	Digital and Health Intelligence	30/11/2025	Red	Overdue	02/09/2025			
Surgery Clinical Board Governance and Financial Management Arrangements	Chief Operating Officer	30/09/2024	Savings Schemes - From the savings tracker, it can be seen that savings have only been identified for £1.52m against the recurrent savings target of £4.626m, leaving a shortfall of £3.106m. As at month 11 the reported shortfall was £3.882m. Almost a third of the savings identified (£425k) had a Red RAG rating so are unlikely to be achieved this financial year.	Corporate Governance - Internal Audit/2024/855/MD3/1	The identification of savings schemes will be prioritised to try and ensure that savings plans are in place to achieve the full savings target set by the Health Board.	Surgical	30/11/2025	Red	Overdue	02/09/2025			

Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	4.1 - Embed data quality governance within key operational and clinical areas of the Health Board. Appoint Data Quality Leads within departments who report directly to senior management to drive accountability and set up regular communication forums, such as quarterly data quality meetings or an internal Teams Channel dedicated to data quality, where updates, best practices, challenges, and successes can be shared. 4.2 - Create a centralised Data Quality Group or Committee to establish accountability for data quality within the Health Board, that has clearly defined roles, responsibilities, and decision-making authority. This committee should be supported by data quality leads across departments to foster engagement at all levels. 4.3 - Develop and implement key data quality metrics as part of the data quality governance structure. These metrics should be designed to track and evaluate the effectiveness of data quality	Corporate Governance - Internal Audit/2025/995/MD4/1	4.1 - Our existing 'Data Insights Group' will evolve into a formal 'Data Steering Group' (DSG) with clinical and operational leadership representation. The DSG will drive aspirational data quality targets, enabling benchmarking across clinical boards. Clinical boards will appoint senior representatives responsible for digital and data, strengthening their participation in organisation-wide data governance.	Digital and Health Intelligence	31/12/2025	Green	Overdue	20/05/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	4.1 - Embed data quality governance within key operational and clinical areas of the Health Board. Appoint Data Quality Leads within departments who report directly to senior management to drive accountability and set up regular communication forums, such as quarterly data quality meetings or an internal Teams Channel dedicated to data quality, where updates, best practices, challenges, and successes can be shared. 4.2 - Create a centralised Data Quality Group or Committee to establish accountability for data quality within the Health Board, that has clearly defined roles, responsibilities, and decision-making authority. This committee should be supported by data quality leads across departments to foster engagement at all levels. 4.3 - Develop and implement key data quality metrics as part of the data quality governance structure. These metrics should be designed to track and evaluate the effectiveness of data quality	Corporate Governance - Internal Audit/2025/995/MD4/2	4.2 - As per 4.1 - "Our existing 'Data Insights Group' will evolve into a formal 'Data Steering Group' (DSG) with clinical and operational leadership representation. The DSG will drive aspirational data quality targets, enabling benchmarking across clinical boards. Clinical boards will appoint senior representatives responsible for digital and data, strengthening their participation in organisation-wide data governance."	Digital and Health Intelligence	31/12/2025	Green	Overdue	20/05/2025			
Core Financials 2024/25	Executive Director of Finance	05/03/2025	Monthly Reconciliations Testing was undertaken on a sample of 20 balance sheet code reconciliations and the results are as follows: • 1 / 20 (Accounts Payable Mth 7) - the reconciliation value did not match that of the financial ledger with a difference of £306.36. • 1 / 20 (Arranged recovery Mth 7) - there was a delay of over three months in the completion of the reconciliation. • 7 / 20 - There was a delay of almost three months from when the reconciliations were completed to when they were authorised. The reconciliations all related to the payroll deductions. • 14 / 20 - the reconciliations included outstanding entries that related to previous financial years with some as far back as 2006/07. The reconciliations all related to payroll deductions and the details were as follows: o Negative Payments (Months 4 and 7) o Whitchurch Mess Fund o Advanced Pay (Months 4 and 7) o Arranged Recovery (Months 4 and 7) o Gross Overpayment (Month 7)	Corporate Governance - Internal Audit/2025/283/MD8/1	We will put appropriate arrangements in place to ensure that all reconciliations are authorised on a timely basis. We will review all reconciliations identified where there are significant numbers of outstanding transactions relating to prior financial years. We will then review all transactions to identify actions required to resolve the queries.	Finance	31/12/2025	Amber	Overdue	20/05/2025			Process has been reviewed and necessary actions are being implemented to improve controls, this is an ongoing process.

Children and Women Clinical Board Governance and Financial Arrangements	Chief Operating Officer	19/12/2025	Core and Key Governance Meeting Terms of Reference documentation - We reviewed key Clinical Board and Directorate governance meetings identified through discussions with Clinical Board senior management and the three Directorate Management teams. Copies of Terms of Reference (ToR) were requested to confirm they were current, clearly defined each group's purpose and objectives, and aligned with the strategic aims of the Directorates, Clinical Board and Health Board. We noted that a number of the groups had no ToR or they were out of date (listed within the report), and a number of the groups whereby version control was not recorded on the ToRs (listed within the report).	Corporate Governance - Internal Audit/2025/1042/MD1/1	All key Clinical Board, Directorate and departmental governance groups will be supported by a Terms of Reference that is regularly reviewed and updated, includes version control, clearly states the group's purpose and objectives and demonstrates alignment with the strategic aims of their Directorate, the Clinical Board and the Health Board.	Children & Women	31/01/2026	Red	Overdue	03/02/2026			
Children and Women Clinical Board Governance and Financial Arrangements	Chief Operating Officer	19/12/2025	Compliance with Terms of Reference requirements and documenting of meetings - We reviewed agendas and minutes for the following key Clinical Board and Directorate governance meetings and confirm that they are operationally compliant with their respective Terms of Reference documents (listed within the report). From our testing, we found that not all meetings were minuted or action plans were produced: • Formal and Combined Clinical Board meeting – Action points were noted in the minutes, but no formal action log was maintained. • CHfW Directorate Management Team (DMT) meeting - No minutes have been recorded for this group during 2025/26 to date. Additionally, the fortnightly Leadership meeting held with the Clinical Board is not supported by any minutes or action log to formalise and support any strategic decision making. • CHfW Quality & Safety Directorate meeting - Membership attendance is not	Corporate Governance - Internal Audit/2025/1042/MD2/1	All Clinical Board governance groups will be supported by minutes to formally record and outline their key/core governance issues and decision making. In addition, action logs should be maintained to ensure that actions are reviewed at each meeting with clearly recorded progress on the actions recorded. Additionally, all minutes will state membership attendees so as to formally record and confirm quoracy.	Children & Women	31/01/2026	Amber	Overdue	03/02/2026			
Deprivation of Liberties Safeguards (DoLS)	Executive Nurse Director	10/09/2025	Assessment time breaches - Whilst the database managed by the MCA Team is accurately maintained, it consistently shows assessments to be breaching the mandated timescales for completion. The Health Board participate in a tripartite agreement through which, six assessments per week are paid for. This was temporarily extended on 7 July to 11 assessments per week with the additional capacity provided by an agency. With an average of ten assessments required per week through Quarter 1 of 2025-26, the baseline of six is insufficient for volumes required. This is demonstrated by the following breakdown of assessments required in the months of Quarter 1: • April – 48. • May – 36. • June – 44. We acknowledge that the MCA Team have submitted business cases requesting additional funding and that to date, these have not been approved.	Corporate Governance - Internal Audit/2025/1023/MD4/1	Management will revise and re-submit their business case requesting additional funding to be made permanent, based on comparison of assessment data between Quarter 2 and Quarter 1.	safeguarding	31/01/2026	Amber	Overdue	18/11/2025			

Charitable Funds	Director of Finance	24/04/2023	An annual operating plan for the fundraising department should be submitted to the Charitable Funds Committee at the beginning of each financial year. The plan should provide specific details regarding the structure of the department, individual staff costs and also non staff costs. Details should also be provided of an estimate of staff costs that can be recharged to specific appeals and funds that the fundraising staff support noting the net costs that can be expected to be recharged to the 'general fund'. An update on the plan should be reported at each meeting of the Charitable Funds Committee noting any changes to the structure that will impact on the 'recharge' to the general fund.	Corporate Governance - Internal Audit/2023/289/MD2/1	The Health Charity is currently reviewing its strategy and in line with good practice has been engaging with CFC members and others to review and redevelop it collaboratively. Part of the strategy review entailed a recognition to include an Annual Operational Plan. This will be developed in Quarter 1 of 2023 and will be reviewed agreed via the Charitable Funds Committee and be embedded as part of its annual governance reporting mechanisms. This will include staff structure, costings and projections on any identified changes to the core staff establishment that require additional funding. Operational changes to staffing, responding and reacting to workforce or project requirements that do not require additional funding from general reserves, specific funds or have external funding will continue to follow the current reporting mechanisms and sign off via the Day to day operational responsibilities of the Director of Communications and sign off by the lead Executive as identified under section 2.27 above.	Finance	28/02/2026	Red	Partially complete (Overdue)	11/05/2023			March 2025 Update - This hasn't been completed yet, so will remain in amber for at least 6-12 months. This is on the basis of an OCP process with the Health Charity Team being conducted and an independent peer review conducted by More Partnership. The Operational Plan is still relevant but forms part of a series of 16 recommendations of which there will be a chronology and time schedule aligned to delivering the recommendations as scrutinised by the established Task and Finish Group reporting into the CFC. 8 July 2024 - The Health Charity Strategy and Operational Plan has been paused whilst the team go through an Operational Change Process (OCP) The Health Charity has developed a draft Operational Plan for 2023/24 which has been submitted to the quarterly Charitable Funds Committee meeting scheduled for 20.06.23*. The plan includes projected income/expenditure and current/projected staff costs for this period. The Health Charity and Charitable Funds Finance team are working collaboratively to ensure that the projected financial plan is regularly revised and updated to reflect actual income/expenditure,
Risk Management and Board Assurance Framework 2025	Director of Corporate Governance	02/04/2025	Risk Management Documentation - The Risk Management and Board Assurance Framework Strategy, and the Risk Management Procedure are past their review date, although there is nothing in the content that is inaccurate, or which does not reflect current practice. However, once the new risk management software is implemented, these documents will need to be reviewed and revised where appropriate. The Risk Appetite Statement is also overdue for formal review.	Corporate Governance - Internal Audit/2025/941/MD1/1	Once the new risk software is fully implemented across the Health Board, the Risk Management and Board Assurance Framework Strategy, the Risk Management Procedure, and the Risk Appetite Statement will be reviewed, revised as appropriate, and approved by the Board.	Corporate Governance	31/03/2026	Amber	Partially complete (Overdue)	20/05/2025			Risk Management Policy updated and approved. BAF Framework with Director of Corporate Governance to review. 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 Risk Management Policy has been updated to reflect the move to AMaT and this was approved by the Audit Committee at its meeting in February 2026. There are some errors in this document which have been communicated to the Corporate Governance Team. None of the other supporting documentation has yet been updated and this is intended for completion once the AMaT software is fully operational.' Action Ongoing - See Finding 1.
Decision Making - ADVISORY	Director of Corporate Governance	20/01/2025	The 'Scheme of Delegation and Earned Autonomy Framework' should be reviewed and updated to ensure thatit is effectively focussed on areas of operational activity and linked to the responsibilities of the Executive Directors. They could then in turn sub-delegate to their Operational Directors as permitted by the Scheme. Management should consider reviewing the Schemes of Delegation from other Health Board's to inform further development of the Cardiff and Vale Scheme. Only the current version of the Scheme should be made available on the Health Board's website and it should be communicated to appropriate personnel including Clinical Board Directors and Directors of Operations for Clinical Boards, to increase their awareness of the Scheme ensure that they are consistently operating in accordance with its requirements.	Corporate Governance - Internal Audit/2025/836/MD1/1	CAUBUHB 'Scheme of Delegation and Earned Autonomy Framework' to be reviewed and updated in line with changes to the UHB planning process	Corporate Governance	31/03/2026	Green	Overdue	04/02/2025			

Integrated Annual Plan	Executive Director of Finance	18/08/2025	Resolving the forecast financial deficit and meeting Welsh Government's financial constraints - In June 2025 confirmation was received from Welsh Government that the Health Board had breached it financial and planning duties, which drew the planning process to a close to focus on delivery and improvement. The letter also set out the next steps the Health Board would be required to take around identifying detailed actions to reduce the deficit to an improved position. This work needs to be urgently undertaken to address the Health Board's underlying financial deficit of £56.2 million which does not meet Welsh Government's target control total of £9.1 million.	Corporate Governance - Internal Audit/2025/999/MD1/1	Management will work to identify plans that will enable the Health Board to make progress towards achievement of the WG target control total over an agreed timescale aligned to targeted intervention de-escalation.	Finance	31/03/2026	Red	Overdue	02/09/2025			
Deprivation of Liberties Safeguards (DoLS)	Executive Nurse Director	10/09/2025	The Health Board does not have a DoLS policy - The Health Board does not have a specific policy on DoLS in line with the Welsh Government guidance. Whilst the Welsh Government guidance provides the benchmark, this should be translated into standardised guidance in the form of a policy that as a minimum: • Explains the Health Board's objectives regarding DoLS; • Provides clarity over roles and responsibilities with regards to DoLS within the Health Board; and • Ensures alignment between the Health Board's operating procedures and mandated legislation. Previous audits undertaken within two other Health Boards identified that they have specific DoLS policies in place.	Corporate Governance - Internal Audit/2025/1023/MD1/1	A DoLS policy will be written, reviewed, approved and implemented. The policy will align to Welsh Government and best practice standards.	safeguarding	31/03/2026	Red	Overdue	18/11/2025			DoLS policy currently in development. Unexpected delay due to responsible postholder covering another post. Following Supreme Court judgement on 2nd June there has been significant change to the law relating to what amounts to a deprivation of liberty. The DoLS policy will need to reflect these changes so will require careful consideration of the new case law.
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	1.1 - Once the data quality strategy has been developed and key initiatives have been defined, it is critical to align the Health Board's policies and procedures to ensure they support the newly established framework. This will help institutionalise the strategy, create consistency in practices, and ensure clear guidance for staff on how to manage and uphold data quality across all systems. 1.2 - Once the data quality policy and related procedures have been updated, the Health Board should ensure that all staff are fully informed about the policy, its content, and its significance. This can be achieved through targeted communication campaigns, such as emails, intranet postings, department meetings, and mandatory training sessions. It is essential to emphasise the importance of adhering to these guidelines in maintaining high-quality data and supporting the organisation's goals.	Corporate Governance - Internal Audit/2025/995/MD1/1	1.1 - We fully agree with this suggestion. The Health Board recognises that aligning policies and procedures with our forthcoming Data Quality Strategy is essential to institutionalising consistent data practices across the organisation. Following the development of our comprehensive Data Quality Strategy (planned for completion by Q4 2025/26), we will promptly update and harmonise key policies, procedures, and guidance documentation. This will provide clear, unified instructions to all staff, significantly strengthening data quality governance, supporting interoperability, and embedding best practices into daily operations. Data should meet the FAIR principles: findable, accessible, interoperable and re-usable. A key reflection is that there is no single action to improve data quality – instead it is a 'system' wide issue and actions must include improvements to processes and procedures, provide greater visibility into data flows and their quality, both real-time and in batch, and improvements to automating feedback and monitoring.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			

Financial Sustainability - Temporary Staffing Controls	Executive Director of Finance / Executive Director of People and Culture	22/12/2025	Medical and Dental Staff Bank – Patchwork system data validation - As part of our review, we obtained and analysed a dataset of medical and dental bank shifts from the Patchwork system to assess whether temporary staffing practices align with the Health Board's financial sustainability objectives. The analysis revealed systemic issues that undermine the intended costcontrol measures. Firstly, we identified significant lead times between request and shift dates, with some shifts requested up to 181 days in advance. This practice contradicts the principle that bank shifts should provide short-term flexibility to cover unforeseen gaps. Instead, it suggests that bank shifts are being used as a substitute for resource/operational workforce planning, which is neither cost-efficient nor sustainable. Secondly, the Medicine Clinical Board accounted for the majority of bank shifts, indicating structural workforce gaps that	Corporate Governance - Internal Audit/2025/1018/MD1/1	Implement system alerts for requests made more than 14 days in advance within the Patchwork system, requiring escalation and justification.	Finance	31/03/2026	Red	Overdue	03/02/2026			
Financial Sustainability - Temporary Staffing Controls	Executive Director of Finance / Executive Director of People and Culture	22/12/2025	Medical and Dental Staff Bank – Patchwork system data validation - As part of our review, we obtained and analysed a dataset of medical and dental bank shifts from the Patchwork system to assess whether temporary staffing practices align with the Health Board's financial sustainability objectives. The analysis revealed systemic issues that undermine the intended costcontrol measures. Firstly, we identified significant lead times between request and shift dates, with some shifts requested up to 181 days in advance. This practice contradicts the principle that bank shifts should provide short-term flexibility to cover unforeseen gaps. Instead, it suggests that bank shifts are being used as a substitute for resource/operational workforce planning, which is neither cost-efficient nor sustainable. Secondly, the Medicine Clinical Board accounted for the majority of bank shifts, indicating structural workforce gaps that	Corporate Governance - Internal Audit/2025/1018/MD1/2	Conduct a resource workforce planning review for Medicine Clinical Board to address structural gaps and reduce dependency on temporary staffing.	Finance	31/03/2026	Red	Overdue	03/02/2026			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	1.1 - Once the data quality strategy has been developed and key initiatives have been defined, it is critical to align the Health Board's policies and procedures to ensure they support the newly established framework. This will help institutionalise the strategy, create consistency in practices, and ensure clear guidance for staff on how to manage and uphold data quality across all systems. 1.2 - Once the data quality policy and related procedures have been updated, the Health Board should ensure that all staff are fully informed about the policy, its content, and its significance. This can be achieved through targeted communication campaigns, such as emails, intranet postings, department meetings, and mandatory training sessions. It is essential to emphasise the importance of adhering to these guidelines in maintaining high-quality data and supporting the organisation's goals.	Corporate Governance - Internal Audit/2025/995/MD1/2	1.2 - We fully support this suggestion. Upon updating our Data Quality Policy and related procedures, the Health Board will implement targeted communication and training strategies to ensure all staff are thoroughly informed of their content, significance, and practical implications. This will include structured email updates, dedicated intranet resources, departmental briefings, and mandatory training sessions tailored to different staff groups. Our goal is to clearly articulate the importance of adhering to these guidelines, reinforcing their role in achieving consistent, high-quality data that underpins the organisation's strategic and operational objectives.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			

Financial Sustainability - Temporary Staffing Controls	Executive Director of Finance / Executive Director of People and Culture	22/12/2025	Medical and Dental Staff Bank – Patchwork system data validation - As part of our review, we obtained and analysed a dataset of medical and dental bank shifts from the Patchwork system to assess whether temporary staffing practices align with the Health Board's financial sustainability objectives. The analysis revealed systemic issues that undermine the intended costcontrol measures. Firstly, we identified significant lead times between request and shift dates, with some shifts requested up to 181 days in advance. This practice contradicts the principle that bank shifts should provide short-term flexibility to cover unforeseen gaps. Instead, it suggests that bank shifts are being used as a substitute for resource/operational workforce planning, which is neither cost-efficient nor sustainable. Secondly, the Medicine Clinical Board accounted for the majority of bank shifts, indicating structural workforce gaps that	Corporate Governance - Internal Audit/2025/1018/MD1/3	Introduce monitoring monthly reports to track long-lead requests and approver concentration. This report will form part of the monthly data review and will be shared with Clinical Board operational leads for their review and action.	Finance	31/03/2026	Red	Overdue	03/02/2026			
Integrated Annual Plan	Executive Director of Finance	18/08/2025	Plans not identified to fully deliver the financial savings requirement - The Minimum Data Set (MDS) spreadsheet submitted to Welsh Government alongside the Annual Plan at the end of March 2025 included a worksheet titled 'F1 – Revenue Plan'. The worksheet sets out the financial movement during 2025/26 from the brought forward underlying deficit of £59.9M to the forecast outturn deficit of £58.2M. The movement includes a total revenue uplift of £22.8M, total cost pressures of £51.1M and a savings requirement of £30.0M. We note that at the time of submitting the MDS, only £7.2M of green and amber savings plans had been identified against the £30.0M requirement and so a further £22.8M of plans needed to be identified and delivered during 2025/26 in order to achieve the forecast outturn deficit. The Health Board's Financial Report for Month 3 of the 2025/26 financial year confirms that the latest position is that £28.6m green and amber savings plans have been identified against the revised £32.0M savings target. The gap of £3.4m in	Corporate Governance - Internal Audit/2025/999/MD2/1	Management will bring forward the planning process to September/October (Q3) to ensure earlier identification of schemes supporting delivery of the 2026/27 savings target.	Finance	31/03/2026	Red	Overdue	02/09/2025			
Financial Sustainability - Temporary Staffing Controls	Executive Director of Finance / Executive Director of People and Culture	22/12/2025	Improve Rota Forecasting and Leave Management to Optimise Substantive Staff Utilisation - Analysis of the Medical and Dental Workforce Bank & Agency Dashboard (Jan–Aug 2025) shows a high reliance on bank staff, with 19,576 shifts filled by the medical staff bank, compared to 215 by agency and 756 unfilled. This suggests gaps in substantive resource/operational workforce planning. The A&E department recorded the highest bank shift volume, with other high-cost areas including General Medicine, Anaesthetics, and Paediatrics. The most frequent reasons for temporary staffing were vacant posts, extra capacity, and sickness, indicating that deployment is often reactive. The absence of a unified electronic rostering system for medical and dental staff limits proactive planning. These patterns point to inefficiencies in rota design and leave management, which may be contributing to avoidable temporary staffing costs and operational strain.	Corporate Governance - Internal Audit/2025/1018/MD2/1	The Health Board will procure and commence implementation of a unified E-Rostering system, starting with foundation Doctors working through to Consultants. In the interim we will continue to use dashboard data to identify high-risk areas and proactively schedule substantive cover.	Finance	31/03/2026	Amber	Overdue	03/02/2026			

Decision Making - ADVISORY	Director of Corporate Governance	20/01/2025	The ToR for the Senior Leadership Board should be reviewed in accordance with the stated frequency and should include more detail as to the agenda items that should be taken to SLB for decisions. The ToR should also provide more clarity on what should be taken to the SLB for decision making and the delegation limits of the SLB.	Corporate Governance - Internal Audit/2025/836/MD2/1	SLB TOR to be reviewed following rapid planning event and refresh of UHB planning process.	Corporate Governance	31/03/2026	Green	Overdue	04/02/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	To undertake an initiative to enhance the inventory of hosted servers by: 2.1 - Updating the inventory to include detailed mappings of each server to the specific applications, services, and functions it supports. This will provide a comprehensive view of the technical environment, helping to identify critical systems and reduce the risk of data silos. It will also aid in better management and oversight of the systems and their interdependencies. 2.2 - Implementing a process to create and maintain detailed data flow diagrams that track the movement of data across systems. These diagrams should illustrate how data is transferred, processed, and stored across various servers and applications, highlighting potential vulnerabilities or bottlenecks in data handling. This will improve transparency and facilitate better decision-making regarding data management, security, and system integrations. 2.3 - Establishing a routine process to	Corporate Governance - Internal Audit/2025/995/MD2/2	2.2 - Our LDR programme will support our vendor-neutral data architecture approach, providing a 'data fabric' representing standards based data flows, and making such data available in repositories using recognised international standards such as OMOP CDM and HL7 FHIR supporting standardisation, aggregation and vendor-neutrality, thus promoting data democratisation and reducing dependency on proprietary schemas.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			
Decision Making - ADVISORY	Director of Corporate Governance	20/01/2025	All Clinical Board's ToR should be subject to periodic review and kept up to date. We consider that there should be one standard ToR template for the Clinical Boards with set text for the areas of common operation. A common template for an action/decision log could be beneficial as it may facilitate the identification of common issues and provide a consistent record of decisions being taken. The ToR for the Clinical Boards should be reviewed and updated to confirm the types of decisions that can be made within the Clinical Board's delegation, in accordance with the Scheme.	Corporate Governance - Internal Audit/2025/836/MD3/1	Clinical Boards Terms Of Reference to be reviewed following refresh of UHB TORs.	Corporate Governance	31/03/2026	Green	Overdue	04/02/2025			

Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	3.1 - Implement a data governance framework that outlines how external engagements are tracked, ensuring that all interactions are properly documented and monitored. This could include creating a central repository for meeting notes, decisions, and action items that are shared across the Health Board. 3.2 - Develop formal training for all Health Board representatives to include data governance, compliance, and ethical decision-making to ensure they manage data responsibly and align with organisational goals in external engagements. Training on communication, data interpretation, and relationship management will help maintain consistency and build strong partnerships. Proficiency in digital tools and risk management will further enhance their effectiveness and reduce potential risks. 3.3 - Set up a dedicated internal Microsoft Teams channel for all Health Board representatives. This channel would serve as a centralised platform for sharing	Corporate Governance - Internal Audit/2025/995/MD3/1	3.1 - Our existing 'Data Insights Group' will evolve into a formal 'Data Steering Group' (DSG) with clinical and operational leadership representation. The DSG will drive aspirational data quality targets, enabling benchmarking across clinical boards (see opportunity 4 below). External engagements relating to data will be tracked via this DSG, engagements relating to technical and data standards will be tracked via our existing Technical Design Authority (TDA), and engagements relating to clinical matters tracked via our existing Clinical Design Authority (CDA). External engagements will include representatives to partner organisations such as regional HBs, PHW, WG and DHCW.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			
Integrated Annual Plan	Executive Director of Finance	18/08/2025	Unreconciled data within the MDS - The Health Board and Trusts were required to complete Minimum Data Set (MDS) spreadsheets as local planning tools which comprise multiple numeric fields for tabulated areas which form the basis for the consolidated data. As part of our testing, we compared the vaccination numbers within the published National Influenza Immunisation Summary (NIIS) data against the MDS for two groups: • Over 65 years of age: The MDS stated the population was 84,045 whereas the NIIS stated the population was 90,696 as at 30 January 2025 and 87,359 as at 27 March 2025. • 2 to 3 years of age: The MDS stated the population was 61,827 whereas the NIIS stated the population was 10,305 as at 30 January 2025 and 10,040 as at 27 March 2025. We compared the population total with the published population estimates by local health boards and year as at mid 2023. The MDS stated the population total was 327,179 whereas the	Corporate Governance - Internal Audit/2025/999/MD3/1	Data included in the MDS spreadsheet will be checked for consistency with published sources of data.	Finance	31/03/2026	Amber	Overdue	02/09/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	3.1 - Implement a data governance framework that outlines how external engagements are tracked, ensuring that all interactions are properly documented and monitored. This could include creating a central repository for meeting notes, decisions, and action items that are shared across the Health Board. 3.2 - Develop formal training for all Health Board representatives to include data governance, compliance, and ethical decision-making to ensure they manage data responsibly and align with organisational goals in external engagements. Training on communication, data interpretation, and relationship management will help maintain consistency and build strong partnerships. Proficiency in digital tools and risk management will further enhance their effectiveness and reduce potential risks. 3.3 - Set up a dedicated internal Microsoft Teams channel for all Health Board representatives. This channel would serve as a centralised platform for sharing	Corporate Governance - Internal Audit/2025/995/MD3/2	3.2 - We will continue our work with colleagues such as Medical Education, our O365 team, our internal training team, our HR/Workforce function to improve these capabilities amongst our workforce. We will perpetuate examples of good work such as the assessment of digital capability undertaken by our nurse colleagues leading on implementation of WNCR which had high reusability to inform what was needed for the EPMA programme and the learning models adopted for each.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			

Risk Management and Board Assurance Framework 2025	Director of Corporate Governance	02/04/2025	Risk Appetite - The Corporate Risk Register currently has no consideration of risk appetite although it does consider target risk.	Corporate Governance - Internal Audit/2025/941/MD4/1	In designing the new risk software, the Health Board will consider the inclusion of risk appetite in the Corporate Risk Register.	Corporate Governance	31/03/2026	Amber	Overdue	20/05/2025			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: 'Currently there is no mention of Risk Appetite in either the Risk Policy instruction or in reporting of CRR to March 2026 Board'. Action Ongoing - See Finding 1.
Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	RASG meeting overview and attendance - The ToR for the Regional Health and Education ALNET Strategic Group (RASG) states that a minimum of 3 of the 5 Local Authorities, as well as a minimum of 2 representatives from each Health Board, which must include the Chair and Vice Chair need to be present for the meeting to go ahead. We reviewed the meetings between February and September 2025 and there were only two Cardiff and Vale health board representatives at two of three meetings, one being the DECLO, who also represents Cwm Taf Morgannwg University Health Board. Key figures from Cardiff Local Authority, the Clinical Director of Allied Health Professionals, and the Director of Nursing have not attended, and Child Health, Emotional Wellbeing and Mental Health (EW & MH) were unrepresented in two out of the three meetings. The February meeting notes confirmed that members are urged to appoint	Corporate Governance - Internal Audit/2025/1002/MD4/1	Automated reminders and calendar invitations will be sent to all individuals required within the Health Board to attend the RASG meetings. These communications will highlight the significance of their participation (including proposals of agenda items in advance of meetings), both in terms of ensuring the meeting's relevance, validity and supporting effective decision-making processes. In addition, a review of the current arrangements for alternate representation will be undertaken to verify their suitability as this may help with the development of the joint overarching strategic vision. As an example, it has been noted that the Senior Lead for Therapies stands in for the Clinical Director for Allied Health Professionals (AHP), but this role only covers a specific segment of the Allied Healthcare Professionals group. The adequacy of such alternative representation will therefore be assessed to ensure comprehensive and appropriate coverage.	Children & Women	31/03/2026	Amber	Partially complete (Overdue)	03/02/2026			Action 1) Completed - A standard automated message has been developed and set up to remind RASG HB members of the importance to attend the meeting (including proposals of agenda items, etc). Action 2) One of the ALN Legislative Review WG recommendation, advised for RPBs have a strategic priority area related to CYP with ALN. The WG held a Spotlight Event held on 4th December involving the members of RPBs to set the scene and initiate the conversation. This was followed up with papers (received 19th March) which summarised the Spotlight Event and set out a schedule of actions - some to be completed by the WG and some by the RPB. The 'Starting Well Board' (a subgroup of the RPB focussing on CYP) held a meeting on 14th April, with as purpose the development of the Starting Well Board's Delivery Plan. A priority area was added to the Delivery Plan to reflect the expectations of the WG. In addition, following a recently meeting with MG (Ca LA Director of Education) it was agreed to hold regular meetings involving senior officers from both the Health Board and LA, with as focus early notification of development of ALP provision and service change. Whether to include VoG LA
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	4.1 - Embed data quality governance within key operational and clinical areas of the Health Board. Appoint Data Quality Leads within departments who report directly to senior management to drive accountability and set up regular communication forums, such as quarterly data quality meetings or an internal Teams Channel dedicated to data quality, where updates, best practices, challenges, and successes can be shared. 4.2 - Create a centralised Data Quality Group or Committee to establish accountability for data quality within the Health Board, that has clearly defined roles, responsibilities, and decision-making authority. This committee should be supported by data quality leads across departments to foster engagement at all levels. 4.3 - Develop and implement key data quality metrics as part of the data quality governance structure. These metrics should be designed to track and evaluate the effectiveness of data quality	Corporate Governance - Internal Audit/2025/995/MD4/3	4.3 - We will work to document our existing local and national data reporting requirements and develop automated quality metrics to identify issues relating to poor data quality. It is likely that a significant data quality gap relates to the clinical coding of diagnostic and procedural events, currently manual and error-prone due to reliance on paperbased processes. Electronic solutions, particularly those capturing procedural codes at the point of care (e.g., theatres), would streamline clinical coding and enhance accuracy through automation supervised by expert coders and such approaches should therefore be prioritised in planning digital investments.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	5 - Develop a formal, structured data quality training program tailored to the specific needs of different departments and roles within the Health Board. This will ensure that all staff understand the critical importance of data quality and how their specific role impacts the accuracy and consistency of data. By providing targeted training, employees will be better equipped to follow best practices for data management and avoid errors that could affect patient care or operational efficiency.	Corporate Governance - Internal Audit/2025/995/MD5/1	We will continue our work with colleagues such as Medical Education, our O365 team, our internal training team, our HR/Workforce function to improve these capabilities amongst our workforce. We will develop upon the existing examples of good work such as the assessment of digital capability undertaken by colleagues leading on implementation of WNCR which had high reusability to inform what was needed for the EPMA programme and the learning models adopted for each within different staff groups. (see opportunity 6).	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			

Community Patient Appliances (Specialist Services CB)	Chief Operating Officer	26/04/2023	Stock counts of the Treforest Unit Stockroom should be undertaken on a monthly basis, and the results shared with Finance and senior leads from the service to ensure prompt investigation into stock balance issues.	Corporate Governance - Internal Audit/2023/899/MD6/1	1. Recruitment underway to support increased staffing in PMC stock, as well as introducing more senior roles to provide greater cover, which in turn will allow regular rolling stock takes across the year culminating in comprehensive annual stock takes at year end. We have also been working closely with the Directorate Accountant who is supporting with our end of year stock take. 2. Governance: - We will adhere to the Corporate stock take guidance issued by Financial Accounts (including the use of sequential numbered stock-count sheets).Evidence: Comprehensive guidance from Financial Accounts has been distributed to senior management as well as stock leads. This is evidenced through emails as well as F2F and team meetings. There is an exception which should be highlighted in relation to numbered stockcount sheets, whereby this is not possible for wheelchairs due the barcoded system. We do however have another robust procedure planned at month end, which will be implemented in March 2023. - Multiple members of the finance team will be onsite during the 22/23 audit to aid compliance	Specialist Services	31/03/2026	Red	Partially complete (Overdue)	01/04/2026	Not having enough staff in the stock team is causing delays to patients receiving their prescribed equipment. Deliveries have been turned away as unable to store stock as previous stock has not been opened and receipted. All these delays are causing long waits on deliveries of new equipment. Delays in getting spares for repairs to wheelchairs. The team is trying to prioritise returns as this reduces purchasing of extra stock when parts may be available onsite.	Active delays in recruitment by health board when positions required are externally funded as part of commissioned services by NWJCC. Savings made at ALAS do not affect the bottom line of the health board as agreed by Cardiff and Vale Finance.	April 2025 - in the process of having a stock rehaul. There is a new stock plan of how to manage stock. They are having regular meetings to discuss the stock processes and procedure. They have been hindered by the lack of staff due to the freeze on recruitment, so clinical and technical staff have been helping. They are looking at making improvements generally across the whole management of stock across the PMC, taking into consideration the health and safety aspects. They will stop ordering stock for the next two weeks to tidy up the storeroom, which will stop deliveries coming in for the week of the 12th May 2025 for a stock overhaul. 5/11/2025 1. Continue to have staffing issues within the posture and mobility stock team. Recruitment currently in progress for 4 new posts. These posts have been interviewed for and offered to applicants. Some applicants start dates are 1/12/2025. Health Board recruitment freeze and processes have caused lengthy delays in filling the posts. Have had a seconded manager in post that didn't work out so currently have a clinician supporting the stock team. The stock team has not had a full compliment of
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	6 - Assess the baseline digital skills across the workforce to identify areas that require further development. This would allow the Health Board to evaluate the current level of digital proficiency among staff and identify areas where improvement is needed. By assessing staff's capabilities in using digital tools and technologies, the Health Board would be able to better understand the specific skill gaps that exist within the workforce. This insight would enable the development of targeted training initiatives that are tailored to meet the varying needs of staff, ultimately improving the effectiveness of digital systems and enhancing operational efficiency. Additionally, this assessment would help ensure that staff are fully equipped to embrace future digital advancements, improving overall adaptability to new technologies.	Corporate Governance - Internal Audit/2025/995/MD6/1	A baseline digital skills assessment will be conducted. We will explore a range of training delivery methods including e-learning platforms, instructor-led interactive sessions, scenario-based workshops, and hands-on practical labs, to effectively cater to diverse learning styles and roles. In line with opportunity 5, we have already recognised that different staff groups require different approaches, and hands-on training may be appropriate for some for example. Similarly, we will look to investigate how value-based appraisal might be used to provide alignment across different clinical boards and disciplines.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			
Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	Nudge Reports - The Nudge Reports provide a weekly overview of statutory duty monitoring for s65 requests and s20 referrals related to ALN. It tracks the volume and timeliness of responses across services, highlighting those approaching or breaching the statutory 42-day and 226-day deadlines. It also flags overdue cases requiring urgent action and shows trends in closed breaches using red and green indicators. During the audit, we examined two nudge reports to assess progress by comparing the status of each Paris ID in PARIS for the weeks commencing 31 August 2025 and 5 October 2025. We reviewed the total number of s65 requests from LA and s20 referrals from both LA and FEIs that had been overdue between 43 and 225 days, requiring urgent action and are classified as Open Breaches. The data revealed that cases relating to Community Paediatric General and General Practice (GP) remained at the same level from August to October, suggesting there was no movement on	Corporate Governance - Internal Audit/2025/1002/MD7/1	As part of the ALN Governance Policy, a process map with supporting narrative will be created to standardise how services monitor and review nudge reports and then take action to address outstanding requests and referrals, ensuring consistency and clear understanding across all teams. Current recipients of the report to confirm continued receipt of the report or suggest an alternative as well as suggest an alternate in case of non-availability, for their service, so that the distribution list is up-to-date and relevant. In addition, the confirmed named individuals on the distribution list will ensure that they understand the expectations linked with the receipt of the weekly nudge report and take appropriate action as relevant.	Children & Women	31/03/2026	Red	Partially complete (Overdue)	03/02/2026			Action 1) Automated email which accompanies the weekly nudge report has been updated to reflect the expectations regarding high levels actions required. In addition a guidance document has been developed which sets out the detailed steps required by the recipients of the weekly ALN nudge report - this is currently out with ALNOG for comments and will be finalised and approved at the next ALNOG meeting (24/06). Once approved, the guidance document will routinely be included with the weekly ALN nudge report email. Action 2) Survey developed to confirm continued receipt of nudge report either as prime recipient or as cc and distribution list updated and shared with PARIS Support Team. Action 3) Once the guidance document has been approved, it will be shared with the people on the confirmed distribution list, with the request to confirm that they understand the expectations linked with the receipt of the weekly nudge report.

Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	7 - Establish a clear structure for data quality management, with a dedicated team to provide oversight and support. While the primary responsibility for driving data quality should rest with the IAOs in each directorate, the data quality team should assist in ensuring consistent monitoring and improvement.	Corporate Governance - Internal Audit/2025/995/MD7/1	The new 'Data steering group' (DSG) will take on this role, making use of existing teams such as Business Intelligence, and LDR, to report on data quality issues and trends, but work with clinical and operational colleagues in an 'all-system' fashion ensuring data quality is 'everyone's business' from the conception, design or procurement of digital and data systems, to the ongoing monitoring and real-time feedback on data quality concerns, and in coordination with clinical and operational colleagues.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	8.1 - Establish a feedback mechanism, such as automated dashboards or reports, to notify relevant departments of data quality issues within their systems. This should be tailored to ensure that departments are made aware of issues that fall under their responsibility and are given the tools and insights necessary to investigate and resolve these problems. By fostering departmental ownership of data quality, the Health Board will empower staff to better understand and address the impact of their data entry practices, leading to improved overall data integrity and reliability. 8.2 - While we understand that financial constraints may limit the ability to allocate additional resources to the BI team, it is recommended that the Health Board consider the potential need for additional resources to develop and expand the BI dashboards as proposed. Expanding their accessibility beyond the BI team would enhance data quality monitoring across departments and improve proactive identification and resolution of data	Corporate Governance - Internal Audit/2025/995/MD8/1	We agree. There are existing investments in data warehousing tools but a existing pilot work to replace 'Signals From Noise' (SfN) using Power BI have progressed well and permit the development of dashboards as well as potentially improving data democratisation through improving access to different data as well as permitting others outside of the core Business Intelligence team to develop dashboards of their own. We would aspire to build a community of practice around these tools to foster re-use and training across the organisation.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			
Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	Statutory Duty Monitoring Meetings - There is inconsistent engagement with the Statutory Duty Monitoring (SDM) process across various services. Notably, the Occupational Therapy (OT) Service, Community Paediatrics, Emotional Well-Being and Mental Health (EWMH) and Paediatric Psychology Services demonstrate poor engagement, neither completing SDM forms nor attending meetings regularly. In contrast, services such as Speech and Language Therapy (SLT), Audiology, Cochlear Implant, Health Visiting, and CALDS show stronger or more reliable engagement, though some (e.g., Health Visiting, PT, Dietetics) have areas for improvement, particularly in timely SDM form completion.	Corporate Governance - Internal Audit/2025/1002/MD8/1	As part of the ALN Governance Policy a process map with supporting narrative will be created to standardise how Services, through their ALN Champion, monitor their ALN compliance and engage with the SDM meetings, ensuring consistency, clear understanding and effective engagement across all teams, as part of the governance control document. In addition, the ALN Champions will ensure that they understand the expectations linked with SDM procedure and take appropriate action as relevant.	Children & Women	31/03/2026	Amber	Partially complete (Overdue)	03/02/2026			A draft ALN Champion expectations, roles and responsibilities overview has been developed and tabled at the ALNOG meeting on 10/02/2026. Further discussion required to agree roles and responsibilities within the context of the ALN Governance Policy. Draft SDM process map to be tabled at the ALNOG meeting on 16/04/2026 for discussion.
Data Quality (Advisory)	Director of Digital & Health Intelligence	06/05/2025	9 - Implement a consistent and systematic approach to investigating and addressing data quality issues, regardless of their scale or impact. Smaller issues should not be deprioritised; instead, a triage process should be established to assess the severity and potential downstream impact of all data issues. This will help ensure that data quality problems are addressed promptly before they escalate into larger, more disruptive issues. A prioritisation framework should be developed, considering both the volume and criticality of data issues, to ensure a balanced approach to data quality management.	Corporate Governance - Internal Audit/2025/995/MD9/1	We expect the 'Data Steering Group' (DSG) to take a lead role in this. The existing 'Data insights group' has had broad membership across digital and operational services and is ready to mature into taking responsibility for providing strategic oversight and a commissioning role for data products, the quality of those data publications and supporting infrastructure.	Digital and Health Intelligence	31/03/2026	Green	Overdue	20/05/2025			

Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	ALNIG Attendance - Our review of ALNIG minutes from January to July 2025 shows that 10 services were not represented by either their ALN champion or alternate representative at any meeting. Community Children Nursing Services or Community Paediatrics have not attended any ALNIG meetings. Five additional services (23%) were only represented once during this period. It is worth noting that one ALN Champion, who oversees three services, was one of the non-attendees. In addition, 11 ALN Champions were also absent during this period. Only five services have been present at all three meetings: Audiology, CALDS, Occupational Therapy, Physiotherapy, and Speech and Language Therapy. The ToR states a quorum is at least one third of members, including the Chair, nine people for 22 Services. In January, ten attended but only six Services were represented. The March meeting was cancelled. The May meeting saw seven	Corporate Governance - Internal Audit/2025/1002/MD10/1	Review the ToR of ALNIG, particularly its membership and differentiate membership in terms of relevance to the service/department/medical specialty. Senior leaders will reiterate the importance of attending the ALNIG meeting, ensuring all services particularly ALN Champions understand their obligations. Senior leaders will directly contact non-attending services to understand barriers (e.g., workload, lack of clarity, competing priorities) and offer support where necessary. The DECLO will share an attendance register with senior leaders who will address ongoing attendance issues related to persistent non-attendance, clearly communicating attendance expectations, and outlining the consequences of repeated absences.	Children & Women	31/03/2026	Red	Partially complete (Overdue)	03/02/2026			24/03/2026 update: Survey developed which proposes different types of membership (ie Core, Attendee in attendance and Attendee for information only) - to be circulated to ALNIG membership and for discussion at ALNIG meeting on 16/04/2026. 24/03/2026 update: Following development and approval of ALN Governance Policy, which will clarify roles and responsibilities, the importance of attendance will be emphasized as well as non attendance will be followed up. 24/03/2026 update: Attendance register has been developed and will be actioned following the implementation of the results of the survey and the approval of the ALN Governance Policy. 27/04/2026 update: Discussed on 16/04/2026 - agreed by members in attendance - nudge email sent to members who have not responded to the survey. 08/07/2026 update: Updated ToR approved by CaV ALNOG - including different types of membership, adjusted quorate formula and classification of agenda items.
GMS Unified Contract Assurance Framework	Chief Operating Officer	21/01/2026	Practice Assessment Visits - Contract and Governance Visit Reports - The Welsh Government Unified Contract Assurance Framework states that 'written feedback (Contract and Governance Visit Report) from the Health Board to be shared with the contractor within 20 working days of visit.' However, Contract and Governance Visit Reports are not being issued to GMS Practices upon completion of Practice Visit Assessments, as PCIC considers their issuance is a duplication of information stated in other forms and reports in place. We note that the PCIC senior management discussed this matter at the All Wales Heads of Primary Care meeting undertaken following the 2023/24 assessment cycle, which was attended by Welsh Government representatives. However, Welsh Government's view on the non-use of the Contract and Governance Visit Reports remains unclear, as does whether other Health Bodies have taken the same approach. Additionally, no formal request has been submitted to	Corporate Governance - Internal Audit/2026/1070/MD1/1	Ensure the formal adoption and consistent use of the Welsh Government-approved Contract and Governance Visit Report template following all Practice Assessment Visits, in full compliance with the Unified Contract Assurance Framework requirements.	Primary, Community & Intermediate Care	01/04/2026	Amber	Overdue	03/02/2026			
Rhydlafar Development	Executive Director of Finance	24/04/2026	Welsh Government Project Progress Reporting - The Health Board are required to report project progress to Welsh Government on a bi-monthly basis via the Project Progress Report (PPR). At the most recent return (January 2026), several aspects were incorrectly presented, including: • Section 10 'Activity Dates' were not updated to reflect the current forecast completion. • Section 11 'Overall Financial Performance' was out of date. • Section 18 'Project Bank Account' had not been completed (see Key Finding 3 above). Accuracy of Project Progress Reports has been raised at prior audits, including most recently, UHW Lift Modernisation (2024/25), Mortuary Refurbishment (2024/25) and UHL Endoscopy (2023/24). The Health Board should review its processes for quality control and sign off to ensure improvements are made in the accuracy of information submitted to Welsh Government.	Corporate Governance - Internal Audit/2026/1185/MD4/1	Individual Project Progress reports to be reviewed and signed off as being accurate by Head of Capital Planning. Financial Performance on PPR's to be reviewed against Monitoring Return sheet prior to issue.	Finance	22/04/2026	Amber	Overdue	19/05/2026			

Rhydlafar Development	Executive Director of Finance	24/04/2026	Planning Tracker - Whilst the project Architect prepared a Planning Tracker in 2021, to log and monitor the status of planning conditions, an updated version was not evidenced. Whilst we have observed the discussion of individual planning conditions within project reports and meetings, a central record which can be periodically shared with the UHB would provide assurance that conditions were being appropriately monitored and achieved.	Corporate Governance - Internal Audit/2026/1185/MD2/1	Project Architect to provide an updated Tracker document to Health Board on a monthly basis presented during the monthly scheme progress meeting.	Finance	27/04/2026	Amber	Overdue	19/05/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Introduce a defined annual-leave workstream within the Medical & Dental Workforce Workplan for 2026/27, setting out clear actions, ownership, milestones and expected outputs.	Corporate Governance - Internal Audit/2026/1041/MD2/1	Annual Leave management hasn't been identified by the senior medical and P&C team as an area that is problematic, so it didn't feature on our 25/26 workplan as a priority. All medical staff use the Codi system (previously Intrepid) for booking annual leave which is managed by HEIW. Other staff groups either use HealthRoster or ESR MSS for recording annual leave. There is a facility in the Medical HealthRoster system to record annual leave, but we'll need to understand whether there is an interface with Codi and how this would be managed. We will scope this out as part of the e-rostering implementation plan.	People & Culture	30/04/2026	Green	Overdue	19/05/2026			
Data Warehouse	Director of Digital & Health Intelligence	26/04/2023	As the LDR is developed, the department should prioritise the development of replacement feeds from the LDR for those feeds that are currently a manual process.	Corporate Governance - Internal Audit/2023/290/MD2/1	An assessment of manual data feeds will be undertaken to identify and document which would be suitable for and benefit from migrating to the LDR. Note actual redevelopment of feeds would be subject to resource and prioritisation in the longer term.	Digital and Health Intelligence	30/04/2026	Amber	Partially complete (Overdue)	11/05/2023			February 2025 - New data warehouse manager in post will pick this action up when priorities allow. Note LDR architecture is not fully in place or resource available to develop new feeds at pace. July 2024 IA tracker update: June 2024 - No Update Mar 2024 - new data feeds are assessed for their suitability to be managed via the LDR however resource constraints in both the warehouse and LDR teams mean replacing existing manual feeds are not currently a priority.
Wellbeing Hub at Park View		01/05/2026	Workstream Activity - Whilst each Workstream had action plans in place (variously termed Activity Plan / Work Plan / Action Plan), the Relocation & Operational Issues (ROI) and Wellbeing & Social Prescribing Ethos and Arts (WSPA) plans did not include target dates for completion of each activity. This reduces the ability to measure and report progress and highlight risks in slippage of key tasks (see also Key Finding 2). Key dates (e.g. aligned to the SCP's programme) were discussed and documented within the minutes and could be added to the action plans for clarity.	Corporate Governance - Internal Audit/2026/1186/MD4/1	Workstream activities will be aligned to the wider project delivery programme with key dates clearly documented and monitored. The Chair of each group to ensure this activity is carried out.	Finance	30/04/2026	Amber	Overdue	19/05/2026			

LIMITED - Cyber Security	Director of Digital and Health Intelligence	15/08/2025	Cyber security governance gaps and communication challenges - • There are inadequate communication channels between the Cyber Security Team and asset owners within the Clinical Boards. • Representatives from the Clinical Boards do not consistently attend the Digital and Infrastructure Committee meetings, nor do they contribute to the cyber security updates presented to the committee. • The organisation's Information Asset Register (IAR) is incomplete. As a result, the Cyber Security Team lacks full visibility of systems, risks and their respective asset owners. • There is a single point of failure due to there being no communication channels or an IAR, as knowledge of asset ownership is heavily reliant on the personal experience of the Head of Information Governance and Cyber Security.	Corporate Governance - Internal Audit/2025/1047/MD4/1	Presentation to SLT which includes the management teams from each Clinical Board to make them aware of requirements of asset owners in relation to managing cyber risks specifically. Information Asset Registers to be completed and shared centrally. A process to be agreed for ensuring appropriate communication channels with CBs. Process to be developed and shared to ensure that CBs become conversant with procedures should a cyber event occur. SLT to agree to a specific forum where Cyber and the CBs can raise and discuss cyber risks, and critical systems along with their key contacts can be determined and logged.	Digital and Health Intelligence	30/04/2026	Red	Overdue	02/09/2025			Work undertaken by Head of Operations requesting CBs to list their most valuable assets. This list has now been shared with Digital to collate and work through to understand business impact on these systems in the event of disruption.
LIMITED - Clinical Board Adherence to the Managing Attendance at Work Policy	Executive Director of People and Culture	05/03/2026	Return to Work Meetings - Of our total sample of 64 sickness records, 58 required a returnto-work meeting with the remaining six not due as the member of staff was still absent at the time of the audit. Of the 58 records that required a return-to-work meeting, only 40 (69%) had been completed. The policy states "the return-towork meeting is conducted on the first day of return or if that is not possible, as early as possible after their return." Of those completed: • 16 (40%) were completed within seven or less days from return to work; • 10 (25%) were completed between 8 and 28 days from return to work; and • 14 (35%) took 29 days or longer to complete.	Corporate Governance - Internal Audit/2026/1053/MD4/1	Communications will be sent out emphasising the importance of return-to-work meetings with context of employee well-being. The importance and timeliness of these meetings will also be emphasised in the digitalised Managing Attendance Training and refresher modules. We will discuss with the Allocate Healthroster team about making mandatory the system fields designed to capture that a return to work meeting has taken place and the date that the meeting occurred.	People & Culture	30/04/2026	Green	Overdue	19/05/2026			Communications have been sent to the triumvirate of each of the Clinical and Service Boards. The importance of return-to-work (RTW) meetings has also been reinforced through our training. The People Services team will continue to advocate for compliance as part of ongoing work, including monthly meetings in identified hotspot areas. Compliance will also be monitored through continued audits undertaken by the People Services team. Discussed with UHB Healthroster team about making mandatory system fields designed to capture self-certification/fit notes. Healthroster team taking this forward with Allocate
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Consolidate sickness and annual-leave data into a single Health Board-wide dataset and standardise ESR-based processes across Clinical Boards. This will strengthen visibility of medical workforce availability, enable consistent capacity planning, and support safe preparation for the All-Wales resident doctors e-rostering implementation.	Corporate Governance - Internal Audit/2026/1041/MD5/2	There is a facility in the Medical HealthRoster system to record annual leave, but we'll need to understand whether there is an interface with Codi and how this would be managed. We will scope this out as part of the e-rostering implementation plan.	People & Culture	30/04/2026	Green	Overdue	19/05/2026			
Wellbeing Hub at Park View		01/05/2026	Analysis of cost increase between OBC and FBC - NHS Wales Infrastructure Investment Guidance states: "A Project Allowance is set at OBC stages under NHS Building for Wales National and Regional frameworks. The Conceptual Proposal established during the Outline Business Case Stage will enable a Project Allowance to be set and agreed with Welsh Government. This will be the maximum amount of funding Welsh Government is prepared to allocate to the project or programme and becomes the approved funding ceiling". A number of changes have impacted the project cost between OBC and FBC. Of note, are the Net Carbon Zero changes, with the Cost Adviser narrating in his target cost report that: "A provisional allowance was provided by the SCP at OBC based on the Decarbonisation Strategy Report prepared by [design advisers] that captured the potential impacts of complying with the Welsh Decarbonisation Standard at the time. However, it would appear the	Corporate Governance - Internal Audit/2026/1186/MD8/1	The scheme passed through scrutiny without any issues being raised and has now been approved by WG.	Finance	30/04/2026	Amber	Overdue	19/05/2026			

Wellbeing Hub at Park View		01/05/2026	Reporting of increasing project costs - WG Capital Guidance Note (September 2023) states "there is an expectation that we will not see significant increases in costs or scope as we move from one stage to the next, particularly after scoping meetings and the SOC and PBC have been endorsed." The guidance therefore requires that, where a cost increase of +10% occurs, WG should be advised immediately to minimise further expenditure on fees and potentially abortive work. The project is also required to escalate risks to the internal Capital Management Group (CMG). The UHB received the SCP's RIBA Stage 3 report in June 2024, outlining the key changes impacting the project design following OBC / RIBA Stage 2. Whilst acknowledging this report did not contain associated costs, the full impact on the project of the required design changes was highlighted.	Corporate Governance - Internal Audit/2026/1186/MD9/1	For future projects a clear written audit trail of communication will be documented with Welsh Government in respect of cost escalation between business case stages. Going forward we will ensure timely reporting of quantified information in relation to cost escalation to CMG and other relevant internal forums.	Finance	30/04/2026	Amber	Overdue	19/05/2026			
Wellbeing Hub at Park View		01/05/2026	Frequency of Meetings - Across all project forums (workstream up to Programme Board), meetings have not been held as frequently as defined within the terms of reference during the period reviewed (prior 12 months). It was noted that the frequency of Project Team meetings had increased in recent months. Whilst recognising there will be acceptable "down time" during certain periods e.g. awaiting FBC approval, some gaps appear unreasonable, e.g. the Project Team did not meet between October 2024 and March 2025. It would be beneficial to review commitment to meetings at each level, in readiness for the next phase.	Corporate Governance - Internal Audit/2026/1186/MD3/1	The reduced frequency of meetings during the period highlighted was due to reduced activity whilst the SCP undertook market testing. Noting the current status of the project, we will ensure monthly meetings are maintained from WG approval through to completion.	Finance	01/05/2026	Amber	Overdue	19/05/2026			
Wellbeing Hub at Park View		01/05/2026	SCP Contract (Confirmation Notice No.1) - The following issues were noted in reviewing SCP Confirmation Notice No.1: • The contract was not dated; • The contract was executed slightly after works commenced (circa 3 weeks); • Whilst the contract refers to a Parent Company Guarantee, this does not appear to have been implemented. Parent Company Guarantees or Performance Bonds should be obtained at all relevant contracts to ensure the UHB is adequately protected. • The contract was not executed in line with Standing Orders (which require Chair/Vice Chair and Chief Executive witnessing of the affixing of the seal). It is recognised this was also raised at the 2024/25 Mortuary audit report and this contract was executed in the same time period. The management response provided at the UHW Mortuary report therefore refers, which provided assurance that all contracts would be signed and sealed in line with relevant procedures (see MA5).	Corporate Governance - Internal Audit/2026/1186/MD5/1	The SCP contract was executed in 2023, this was prior to the Mortuary report being issued. Since the Mortuary project audit report the Health Board has worked closely with Shared Service procurement to ensure all contracts are in line with all procurement SFI's.	Finance	01/05/2026	Amber	Overdue	19/05/2026			

Rhydlafar Development	Executive Director of Finance	24/04/2026	Key Performance Indicators - The C&VUHB Local Framework requires contractor Key Performance Indicators (KPIs) to be completed every six months. KPIs had not been completed to date for this project. In addition to ensuring these are now captured, the team may wish to review arrangements for ensuring KPIs are submitted at the required intervals across its live projects, to support central monitoring as intended. We note that provision was also not made for KPIs at the adviser appointments. The UHB should consider whether this would be beneficial at future projects.	Corporate Governance - Internal Audit/2026/1185/MD1/1	It has been agreed with NWSSP Procurement team that a formal KPI review meetings will be carried out with each appointed Contractor on the Framework. The review meeting for this project is planned for May 2026 with the review for all other projects being complete by the end of June 2026. This project review will also encompass external advisors on Capital Schemes.	Finance	31/05/2026	Amber	Overdue	19/05/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Strengthen the Workplan for 2026/27 by adding explicit risks, dependencies, realistic milestones and broader KPIs to improve deliverability and clarity.	Corporate Governance - Internal Audit/2026/1041/MD1/1	The Workplan was developed at pace to ensure that our strategic priorities were captured alongside the National Programmes of Work that are led by NHSWE. The intention was to use it as a live document to track progress, unfortunately this hasn't worked due to the information being captured in other places, e.g. WG Enabling Actions, WRDC implementation, etc. We accept that the Workplan needs to be strengthened for 26/27 focusing on a few key strategic priorities, e.g. implementation of E-Rostering system, WRDC, improvement in job planning, implementation of All Wales Job Planning Policy.	People & Culture	31/05/2026	Green	Overdue	19/05/2026			
Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Digital Literacy/Capability Assessment - There should be a clear, agreed, and consistent approach across the organisation for assessing staff digital literacy and capability. While the Building a Digital Workforce section of the People and Culture Plan (2022–2025) outlines intentions to develop a digital skills framework and conduct a skills assessment to map staff competency, progress remains at an early stage. Given that other strategic plans also identify improving digital literacy as a priority, it is recommended that this work is formalised, resourced, and prioritised to enable the development and implementation of a standardised assessment methodology across the Health Board. If the HEIW Digital Capability Framework self-assessment tool is not fit for purpose, then this needs to be communicated with them and new assessment created to capture the current digital literacy of staff throughout the organisation.	Corporate Governance - Internal Audit/2026/1162/MD1/1	1. Meet with HEIW to explore future plans for increasing digital capability across NHS Wales, revisit concerns re: the national tool and to explore HEIW support for UHB work. 2. Explore role-based skills assessments undertaken by other NHS Wales organisations e.g. ABUHB and local external providers e.g. Cardiff and Vale College. 3. Development of a Digital learning Academy (DLA) (as per point 2) and multi-professional faculty to host and lead this stream of work. 4. Mapping workshop with key stakeholders to develop and agree the UHB approach to the assessment of baseline digital proficiency skills, the resource required and current capacity to support. 5. Work with DLA Faculty to refine a quality improvement-based programme of work to undertake an inclusive assessment across all roles, which is based on existing capacity only. Develop options appraisal which articulates programme potential with additional resource.	Digital and Health Intelligence	31/05/2026	Green	Overdue	19/05/2026			

Rhydlafar Development	Executive Director of Finance	24/04/2026	Project Bank Account - Welsh Government Procurement Policy Note (WPPN) 010 requires the use of Project Bank Accounts for all construction projects that receive Welsh Government funding. There are three cases for exemption, none of which are met by this project. Standing Financial Instructions (section 15.4.8) also state that "The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons". The BJC approved by the Board and Welsh Government stated "The Health Board … can confirm that a Project Bank Account (PBA) will be prepared as the project exceeds the Welsh Government value threshold for the mandatory use of Project Bank Accounts." Following approval of the BJC, the main contractor stated their intention to "opt-	Corporate Governance - Internal Audit/2026/1185/MD3/1	Head of Capital Planning to ensure Project Bank accounts will be in place as per Welsh Government funding requirements on all future Capital Schemes. Head of Capital Planning to ensure all Bi-monthly project progress returns include status of PBA.	Finance	31/05/2026	Amber	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Escalation Process - Review of 15 red-flags issues across 10 wards, covering day, night, and weekend shifts, confirmed that staffing shortfalls are being appropriately identified and recorded, and staffing huddles are held to discuss mitigation actions. The red flags reviewed related to key risk areas, including unmet patient acuity, insufficient number of Health Care Support Workers (HCSW) or registered nurses, and unmet 1:1 care requirements. However, for 11 of the 15 red flags reviewed, SafeCare records remained "open" despite mitigation actions reportedly having been completed. This indicates that, while escalation and responses mechanisms are operating effectively, the recording and closure of outcomes within SafeCare is not consistently completed within expected timescales.	Corporate Governance - Internal Audit/2026/1129/MD3/4	Action 4 – Routine Monitoring and Oversight • Implement routine monitoring of open SafeCare red flags beyond ward based action and feedback to relevant areas to action. • Identify and follow up red flags remaining open beyond expected timescales by Nurse Staffing Lead.	Corporate Nursing	31/05/2026	Amber	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Displaying of Nurse Staffing Levels on wards - We reviewed 15 wards to ensure that the nurse staffing levels were being displayed and identified the following issues: • Wards A7, A5 and B4 - These wards had no nurse staffing level information displayed. • Ward B7 - This ward displayed information that was outdated, referencing a Board presentation date of May 2025. • Wards A6 and A4 - These wards displayed templates where the date last presented to the Board was left blank. • Wards B7, A6 and A4 - These wards displayed information in English only, contrary to Welsh Language Standards and statutory guidance requiring bilingual presentation. • Wards B7, A6 and A4 - These wards had not displayed the number of nurses and healthcare/nursing support required for day-to-day care, however it must be noted that these wards appeared to be using outdated templates.	Corporate Governance - Internal Audit/2026/1129/MD4/1	Action 1 – Ward Walk rounds and Immediate Assurance - Ward walk rounds will be undertaken to ensure that all ward areas display the required nurse staffing information clearly and in accordance with statutory requirements. • Walk rounds will confirm the presence, accuracy and visibility of nurse staffing information for patients and visitors.	Corporate Nursing	31/05/2026	Amber	Overdue	19/05/2026			

Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Digital Capability Workgroup/Project - The ECOD team are planning on initiating a project to assess the digital capability/literacy of staff within the organisation. While it is in its early stages, the following will need to be considered (as well as the points highlighted within other Management Considerations): • There will need to be engagement from staff across the organisation and clear communication will be essential. • The purpose and benefits of completing the assessment will need to be communicated with staff, also highlighting that this is a supportive tool to help with development. • Staff with all levels of digital literacy need to be considered, ensuring the assessment is inclusive and does not disadvantage any groups. • The assessment platform will need to be accessible to all staff, with support available for those at the early stages of their digital development. • Time allocation for completion is critical; the 45-minute HEIW DCF self-assessment was considered too long.	Corporate Governance - Internal Audit/2026/1162/MD4/1	1. Project will be led by the DLA Faculty. As per previous sections. 2. Identify subject matter experts/champions working across professional groups who can join the academy and work in collaboration with the faculty to enable an inclusive role-based approach to assessment and training. 3. Work with responsible executives to clarify and articulate the digital literacy and capability responsibilities for all leadership levels across the UHB. 4. Undertake a risk assessment with the DLA Faculty so that risks associated with limited capacity to deliver are clearly articulated and understood.	Digital and Health Intelligence	31/05/2026	Green	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Displaying of Nurse Staffing Levels on wards - We reviewed 15 wards to ensure that the nurse staffing levels were being displayed and identified the following issues: • Wards A7, A5 and B4 - These wards had no nurse staffing level information displayed. • Ward B7 - This ward displayed information that was outdated, referencing a Board presentation date of May 2025. • Wards A6 and A4 - These wards displayed templates where the date last presented to the Board was left blank. • Wards B7, A6 and A4 - These wards displayed information in English only, contrary to Welsh Language Standards and statutory guidance requiring bilingual presentation. • Wards B7, A6 and A4 - These wards had not displayed the number of nurses and healthcare/nursing support required for day-to-day care, however it must be noted that these wards appeared to be using outdated templates.	Corporate Governance - Internal Audit/2026/1129/MD4/2	Action 2 – Wards A7, A5 and B4: Absence of Displays - The approved nurse staffing display template will be issued to Wards A7, A5 and B4. • Templates will be completed in partnership with Ward Managers to ensure accuracy. • Ward Managers will be reminded of the statutory importance of displaying nurse staffing information to patients under the Nurse Staffing Levels (Wales) Act 2016.	Corporate Nursing	31/05/2026	Amber	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Displaying of Nurse Staffing Levels on wards - We reviewed 15 wards to ensure that the nurse staffing levels were being displayed and identified the following issues: • Wards A7, A5 and B4 - These wards had no nurse staffing level information displayed. • Ward B7 - This ward displayed information that was outdated, referencing a Board presentation date of May 2025. • Wards A6 and A4 - These wards displayed templates where the date last presented to the Board was left blank. • Wards B7, A6 and A4 - These wards displayed information in English only, contrary to Welsh Language Standards and statutory guidance requiring bilingual presentation. • Wards B7, A6 and A4 - These wards had not displayed the number of nurses and healthcare/nursing support required for day-to-day care, however it must be noted that these wards appeared to be using outdated templates.	Corporate Governance - Internal Audit/2026/1129/MD4/3	Action 3 – Ward B7: Outdated Information - The Ward Manager for B7 will be advised that the displayed information is outdated. • The template will be updated to reflect the correct and current date of last Board review. • The importance of updating nurse staffing displays following Board review and approval will be reinforced.	Corporate Nursing	31/05/2026	Amber	Overdue	19/05/2026			

Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Displaying of Nurse Staffing Levels on wards - We reviewed 15 wards to ensure that the nurse staffing levels were being displayed and identified the following issues: • Wards A7, A5 and B4 - These wards had no nurse staffing level information displayed. • Ward B7 - This ward displayed information that was outdated, referencing a Board presentation date of May 2025. • Wards A6 and A4 - These wards displayed templates where the date last presented to the Board was left blank. • Wards B7, A6 and A4 - These wards displayed information in English only, contrary to Welsh Language Standards and statutory guidance requiring bilingual presentation. • Wards B7, A6 and A4 - These wards had not displayed the number of nurses and healthcare/nursing support required for day-to-day care, however it must be noted that these wards appeared to be using outdated templates.	Corporate Governance - Internal Audit/2026/1129/MD4/4	Action 4 – Wards A6 and A4: Missing Review Dates - Ward Managers for A6 and A4 will be instructed to update displays to ensure the date of last review is clearly stated. • Compliance will be verified during follow-up checks.	Corporate Nursing	31/05/2026	Amber	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Displaying of Nurse Staffing Levels on wards - We reviewed 15 wards to ensure that the nurse staffing levels were being displayed and identified the following issues: • Wards A7, A5 and B4 - These wards had no nurse staffing level information displayed. • Ward B7 - This ward displayed information that was outdated, referencing a Board presentation date of May 2025. • Wards A6 and A4 - These wards displayed templates where the date last presented to the Board was left blank. • Wards B7, A6 and A4 - These wards displayed information in English only, contrary to Welsh Language Standards and statutory guidance requiring bilingual presentation. • Wards B7, A6 and A4 - These wards had not displayed the number of nurses and healthcare/nursing support required for day-to-day care, however it must be noted that these wards appeared to be using outdated templates.	Corporate Governance - Internal Audit/2026/1129/MD4/5	Action 5 – Bilingual Compliance and Template Updates (B7, A6 and A4) - Wards B7, A6 and A4 will be required to display bilingual (Welsh and English) nurse staffing posters in line with Welsh Language Standards and statutory guidance. • Outdated templates will be removed and replaced with the current approved version. • Updated displays will clearly state the number of registered nurses and nursing support staff required for day-to-day care.	Corporate Nursing	31/05/2026	Amber	Overdue	19/05/2026			
Wellbeing Hub at Park View		01/05/2026	Adviser Contracts - The following issues were noted in reviewing the Adviser (Project Manager and Cost Adviser) contracts for the FBC stage: 1. The Project Manager contract was not executed in line with Standing Orders (which require Chair/Vice Chair and Chief Executive witnessing the affixing of the seal) (see Mortuary report MA5 as above); 2. The Health Board's capital procedures require either a Service Level Agreement (SLA) or NEC Professional Services Contract (PSC) to be used for adviser appointments. The NEC form of contract provides clearly defined liabilities, warranty requirements, early warning processes, and structured change control arrangements, and fully aligns with the NEC construction contract and other adviser contracts. Whilst the NEC PSC was used for the Project Manager appointment in line with the Building for Wales Framework conditions, the Shared Business Services (SBS) Framework SLA was used for the Cost Adviser appointment. The Full Business Case states that the NEC PSC has been used for	Corporate Governance - Internal Audit/2026/1186/MD6/1	The Project Manager contract was executed in 2023, this was prior to the Mortuary report being issued. Since the Mortuary project audit report the Health Board has worked closely with Shared Service procurement to ensure all advisor contracts are in line with all procurement SFI's. We will assess the potential benefits/costs of implementing the NEC Professional Services Contracts in conjunction with NWSSP Procurement to agree best practice going forward and enhanced guidance for projects will be included within the C&V Capital Project manual.	Finance	31/05/2026	Amber	Overdue	19/05/2026			

Wellbeing Hub at Park View		01/05/2026	Target Cost Report - Whilst recognising the Cost Adviser appointment was not made via the national Building for Wales Framework (as these services were not available from the Framework at the time), the Cost Adviser Schedule of Services for the Framework (section 3.6.8) requires the Cost Adviser to prepare a report covering matters such as level of market testing, affordability, commercial issues and value for money, and to include a recommendation as to whether the bid should be accepted. NWSSP: Specialist Estates Services (SES) confirm that health boards were advised to utilise the Schedule when appointing advisers outside the Framework. The Target Cost report was received from the Cost Adviser in July 2025, after the capital element of the draft FBC had already been endorsed at Capital Management Group. We understand the report was prepared on recommendation from NWSSP:SES, to ensure the cost changes from OBC to FBC were adequately explained.	Corporate Governance - Internal Audit/2026/1186/MD7/1	The Health Board will ensure Target Cost reports are received in advance of decisions made at future projects. We will refer to the Framework Cost Adviser Schedule of Services as best practice for major projects.	Finance	31/05/2026	Amber	Overdue	19/05/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Review and update the MWAG Terms of Reference to reflect current reporting lines (including the People & Culture Committee), revised governance expectations, and the updated scope of MWAG's strategic and operational responsibilities.	Corporate Governance - Internal Audit/2026/1041/MD7/1	The terms of reference will be reviewed, amended and approved	People & Culture	31/05/2026	Green	Overdue	19/05/2026			
Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Clarify Leadership and Strengthen Coordination for Digital Literacy - The organisation should formally identify and communicate which part of the organisation holds responsibility for leading efforts to assess and improve staff digital literacy. This includes accountability for the overall approach, delivery, and associated training. Clear and visible ownership will ensure staff understand where this work sits, who is leading it, and where to seek guidance and support. In addition, the Health Board should improve communication and coordination between Digital Services and People & Culture to ensure a unified approach. While their objectives may differ, both share the overarching goal of enhancing staff digital capability. Coordinated working, overseen by the designated lead service, will help avoid duplication, ensure consistent messaging, and provide a single point of accountability for digital literacy initiatives.	Corporate Governance - Internal Audit/2026/1162/MD2/1	Development of a UHB Digital Learning Academy (DLA) which is jointly led by Education and Digital Services. The Academy will be led by a multi-professional faculty who will lead an inclusive UHB wide digital literacy and capability assessment.	Digital and Health Intelligence	01/06/2026	Green	Overdue	19/05/2026			

Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Microsoft 365 Training - M365 training videos are available on the intranet, but at around an hour long, these are likely to be too long for staff to find the time to complete in their entirety. While the M365 Programme intranet page links to the DHCW Centre of Excellence (CoE), which provides training information and short videos, these resources are not targeted to local needs and may require further promotion across the workforce. Bitesize sessions were mentioned numerous times by stakeholders, and to improve accessibility, the development of these could be further explored. The M365 Team confirmed there is a demand for this type of training and noted that it could reduce individual support requests to their team. However, they do not currently have capacity to produce it, and no external provider is in place. The Health Board should explore allocating dedicated internal resource or secure an approved external provider to design and maintain a consistent M365 training offer, ensuring	Corporate Governance - Internal Audit/2026/1162/MD7/1	1. Cross reference skills assessment output and training needs analysis with availability of 365 training. 2. Cardiff and Vale College have agreed to develop a suite of funded accredited learning opportunities for UHB staff following completion of the UHB's assessment and training needs analysis. 3. Review existing training offers and host information, links and associated governance processes within DLA. 4. UHB communication plan to support launch of DLA.	Digital and Health Intelligence	01/06/2026	Green	Overdue	19/05/2026			
Neurodevelopmental Services – Children	Chief Operating Officer	27/04/2026	Triage Capacity - The team undertaking triage comprises a Clinical Triage Lead and one Band 6 member of staff. The original plan for the team had two Band 6 roles to undertake the triage which would have allowed the Clinical Triage Lead to undertake some development work with schools to identify early interventions with children that may have negated the need for a formal referral in some cases. The additional role would also provide cover in the event of annual leave or sickness absence. Having only one Band 6 member of staff results in the development work with schools not being able to be undertaken and provides little resilience in the case of absence of either of the current team members.	Corporate Governance - Internal Audit/2026/1187/MD1/1	Acknowledging the financial constraints on the Health Board, the decision to only appoint to one of the two Band 6 posts will be reviewed to consider whether the potential reductions in referrals, and the additional team resilience in the event of absence, would justify the additional cost.	Children & Women	30/06/2026	Amber	Overdue	19/05/2026			
Neurodevelopmental Services – Children	Chief Operating Officer	27/04/2026	Automated Notifications - At the time of our review work was being undertaken on the possible automation of outcome letters from the triage assessment. This would save staff significant time if implemented, but there is a risk that the letters might become too generic and impersonal, particularly where children are not accepted onto the waiting list.	Corporate Governance - Internal Audit/2026/1187/MD2/1	The Service will continue to explore the potential for automating triage outcome notifications but also ensure that by doing so, the letter to children and their families do not become too generic and impersonal.	Children & Women	30/06/2026	Amber	Overdue	19/05/2026			
Occupational Health Services	Executive Director of People and Culture	28/04/2026	Occupational Health Policy - At the time of our audit fieldwork, it was noted that there is currently no formal policy in place for Occupational Health Services. We also note that the current version of the Employee Health and Wellbeing Policy (UHB 456) available on SharePoint is overdue for review, having last been due for review in June 2019. In addition, the policy does not make any reference to Occupational Health. Our review of other NHS Wales health bodies found that some organisations had a standalone policy whilst for others the information regarding Occupational Health was included within the Employee Wellbeing Policy.	Corporate Governance - Internal Audit/2026/716/MD2/1	We will review the Health and Wellbeing UHB policy. As part of this process, consideration will be given to formally incorporating Occupational Health within this policy or, where appropriate, developing a standalone Occupational Health policy.	People & Culture	30/06/2026	Amber	Overdue	19/05/2026			

Nurse Staffing Levels	Executive Nurse Director	05/05/2026	SafeCare completion - Review of a sample of 10 wards identified that, while SafeCare input was generally completed within the required parameters, a number of compliance issues remained. The E-rostering Project Manager advised that an agreed compliance threshold of greater than 90% for completion of the SafeCare census is in place, as set out within the Rostering Principles. Analysis of SafeCare completion data across the sampled wards over a sixmonth period identified the following: • Overall SafeCare completion averaged 93% for daytime entries and 90% for night-time entries. • Ward B7 demonstrated lower levels of compliance, with average completion rates of 84% during the day and 72% at night. • Ward C5 recorded a morning completion rate of 82%. • Ward B6 recorded a night-time completion rate of 86%. • Ward B5 recorded a night-time completion rate of 87%. • Ward A2 recorded a night-time	Corporate Governance - Internal Audit/2026/1129/MD2/1	Action 1- SafeCare Completion Accountability - Accountability will be reinforced with Ward Sisters/Charge Nurses regarding their responsibility for shift-by-shift SafeCare completion, with Senior and Lead Nurses made aware to provide appropriate oversight.	Corporate Nursing	30/06/2026	Amber	Overdue	19/05/2026			
Neurodevelopmental Services – Children	Chief Operating Officer	27/04/2026	Management of Waiting Lists - A lack of administrative support results in there being no proactive management of the waiting lists which at the time of our review were three and a half years long. There is an automated system called the Digital Appointment Booking System (DABS) which could facilitate the sending of regular update letters to those on the waiting list to confirm that they wish to remain on it.	Corporate Governance - Internal Audit/2026/1187/MD3/1	The Health Board will consider the use of DABS to ensure that the waiting lists remain accurate and that children and their families receive some form of update whilst they are waiting for an appointment.	Children & Women	30/06/2026	Amber	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Escalation Process - Review of 15 red-flags issues across 10 wards, covering day, night, and weekend shifts, confirmed that staffing shortfalls are being appropriately identified and recorded, and staffing huddles are held to discuss mitigation actions. The red flags reviewed related to key risk areas, including unmet patient acuity, insufficient number of Health Care Support Workers (HCSW) or registered nurses, and unmet 1:1 care requirements. However, for 11 of the 15 red flags reviewed, SafeCare records remained "open" despite mitigation actions reportedly having been completed. This indicates that, while escalation and responses mechanisms are operating effectively, the recording and closure of outcomes within SafeCare is not consistently completed within expected timescales.	Corporate Governance - Internal Audit/2026/1129/MD3/1	Action 1 – Clarify Accountability for SafeCare Closure • Reinforce that the Ward Manager or Nurse in Charge for the shift is responsible for ensuring that SafeCare red flags are closed once mitigation actions have been completed. • Make closure of SafeCare records a clear expectation within ward governance responsibilities. • Compliance will be monitored through routine productivity and performance review meetings at Director of Nursing and Clinical Board level.	Corporate Nursing	30/06/2026	Amber	Overdue	19/05/2026			

Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Escalation Process - Review of 15 red-flags issues across 10 wards, covering day, night, and weekend shifts, confirmed that staffing shortfalls are being appropriately identified and recorded, and staffing huddles are held to discuss mitigation actions. The red flags reviewed related to key risk areas, including unmet patient acuity, insufficient number of Health Care Support Workers (HCSW) or registered nurses, and unmet 1:1 care requirements. However, for 11 of the 15 red flags reviewed, SafeCare records remained "open" despite mitigation actions reportedly having been completed. This indicates that, while escalation and responses mechanisms are operating effectively, the recording and closure of outcomes within SafeCare is not consistently completed within expected timescales.	Corporate Governance - Internal Audit/2026/1129/MD3/2	Action 2 – Targeted Training and Reminders • Deliver targeted refresher training or briefings for Ward Managers and senior shift leaders where red flags are not being closed in a timely manner. • Include SafeCare closure requirements in Ward Manager induction- to discuss with our Education Department.	Corporate Nursing	30/06/2026	Amber	Overdue	19/05/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Escalation Process - Review of 15 red-flags issues across 10 wards, covering day, night, and weekend shifts, confirmed that staffing shortfalls are being appropriately identified and recorded, and staffing huddles are held to discuss mitigation actions. The red flags reviewed related to key risk areas, including unmet patient acuity, insufficient number of Health Care Support Workers (HCSW) or registered nurses, and unmet 1:1 care requirements. However, for 11 of the 15 red flags reviewed, SafeCare records remained "open" despite mitigation actions reportedly having been completed. This indicates that, while escalation and responses mechanisms are operating effectively, the recording and closure of outcomes within SafeCare is not consistently completed within expected timescales.	Corporate Governance - Internal Audit/2026/1129/MD3/3	Action 3 – Daily Shift and Huddle Prompt • Reinforce a standard prompt within staffing huddles and shift handovers that there is a requirement to: • Review any open SafeCare red flags during that shift. • Confirm whether mitigation actions have been completed. • Close SafeCare records when appropriate during that shift.	Corporate Nursing	30/06/2026	Amber	Overdue	19/05/2026			
New IT service Desk System	Director of Digital and Health Intelligence	25/01/2023	1.1 A Standard Operating Procedure should be developed for the monitoring of open calls and calls set to 'Waiting for Customer' status. Customers with calls set to 'Waiting for Customer' status should receive two reminders, and these calls should be closed if the customer fails to respond after the second reminder. 1.2 Consideration should be given to making the target resolution date a mandatory field for all calls.	Corporate Governance - Internal Audit/2023/280/MD5/1	1.1 Service Desk Standard Operating Procedures have been created as part of the implementation. Standard reporting within the software has been configured to report Incidents and Service Requests which has passed baseline SLAs. Advanced reporting is currently being installed and configured using dynamic Microsoft Power Business Information reporting tools. 1.2 Target resolution date is already configured within the system, as this is linked to the SLA. Inclusion of a target resolution date is difficult to predict for nonstandard requests due to external factors, however, an indicative date will be included.	Digital and Health Intelligence	30/06/2026	Red	Partially complete (Overdue)	07/02/2023			July 2024 IA tracker update: June '24 - Open calls can be reported on through the PowerBI setup available on Teams but waiting on calls is in development. We are looking to automate the reminders. Target date is a predefined field and exists on all calls. SLTs for service requests - service level target dates and SLAs for incidents. These need to be agreed with other teams and departments. April 2025 - it is partially complete, but made no real progress since July. This will be made a priority to request that it is configured, and would be automatic.

Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Communication, Visibility and Access to Training - Multiple stakeholders highlighted that it was not clear what digital training was available, who provides it and how/where it can be requested or found. It is acknowledged by the audit team that digital training is available in the 'My Digital Gateway' page of the intranet site, this may need to be promoted amongst staff and managers more, or a searchable digital training catalogue created. In addition, if all digital training and development will be accessed via the intranet site or requested through Ivanti, it is important that staff know how to navigate these pages and systems effectively.	Corporate Governance - Internal Audit/2026/1162/MD5/1	1. Scoping activity to clarify existing training resources in UHB and externally e.g. DHCW and local providers in receipt of apprenticeship funding. 2. Host training information in the DLA – thus providing a single front door to training resources. 3. Develop a robust inclusive comms plan to communicate resources across all staff groups, in particular those who rarely/never access digital systems. 4. Seek user experience feedback on accessibility and usability and use this to drive continuous improvement in the materials available.	Digital and Health Intelligence	30/06/2026	Green	Overdue	19/05/2026			
Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	ALN KPI Monthly Dashboard and PARIS ALN Module amendments - A monthly KPI dashboard is in the process of being developed to report of a monthly basis the compliance of the HB with its statutory ALN duties. While initiated in 2024, the dashboard remains in progress and has not yet been finalised. Its primary objective is to offer a comprehensive summary of validated statutory duties compliance for each reporting period. The absence of long-term data makes it difficult to track departmental progress or identify unresolved cases. Present reporting does not indicate that all departments are proactively monitoring, scrutinising or addressing outstanding statutory duties issues. Due to limited access to PARIS development resources, modifications, amendments, and additional updates require significant time. Consequently, since February 2025, the DECLO team has implemented a PARIS tracker to monitor	Corporate Governance - Internal Audit/2025/1002/MD9/1	The ALN dashboard will be finalised to capture all key metrics (requests received, completed, outstanding, categorised by type and reporting period) and relevant staff will receive training on the ALN dashboard as relevant to their role and ALN related responsibilities. The ALN dashboard will be discussed at service/department/medical specialty governance meetings, for monitoring and reporting purposes and breaches will be investigated and followed up. Services/Departments/Medical Specialties will report their ALN compliance ultimately to the Board, via the established governance routes, in order to provide the necessary assurance. As part of the ALN Governance Policy a process map with supporting narrative will be created to standardise how Services ensure consistent use and escalation of unresolved cases, with progress reported within the service groups. Regular 'PARIS development time requires to be assigned to 1) finalise the development of the ALN KPI dashboard 2) address the	Children & Women	30/06/2026	Amber	Overdue	03/02/2026			
Wellbeing Hub at Park View		01/05/2026	Project Board Role - In reviewing the function of the SOFW IOC Programme Board in delivering the defined "project board" role agreed within its terms of reference, issues were noted in the quality and consistency of reported project information. This reduced the information available to support the Programme Board in fulfilling its responsibilities of project oversight and control. The Programme Board was replaced by the Regional Partnership Board Capital Coordination Group in May 2025. The new forum does not assume the same "project board" role but instead seeks high-level assurance from individual Project Boards. As the UHB now lacks an internal forum acting as Project Board for the Park View project, clarification is required as to how this requirement will be fulfilled, along with the wider "project board" responsibilities previously defined within the SOFW IOC terms of reference. At previous audits we have raised the	Corporate Governance - Internal Audit/2026/1186/MD1/1	The roles of the Project Board and Project Team, and their agreed function is included within the C&V Capital Procedures Manual. As this document is still currently in draft format the C&V project team will continue to report to the Capital Management Group, this high level group will provide the level of assurance required by the RPB CCG until the updated Capital Manual is approved and changes are implemented.	Finance	31/07/2026	Amber	Overdue	19/05/2026			

LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Awareness of the All Wales Flexible Working Policy - The All Wales Flexible Working Policy is accessible to all staff via the Workforce Policies section and the Flexible Working toolkit within the People and Culture area of SharePoint. However, our testing identified that some staff working compressed hours or variable hours had not completed a Flexible Working Request form or submitted a request via ESR for approval by their line manager, as required by the policy. This demonstrates a lack of awareness of the policy requirements.	Corporate Governance - Internal Audit/2026/1107/MD1/1	Issue a management briefing on the Flexible Working Policy and Annual Leave Procedure, supported by targeted communications to line managers and staff. Include clear expectations for compressed hours, variable hours, annual leave recording, and bank holiday treatment.	People & Culture	31/07/2026	Amber	Overdue	01/09/2026			
LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Awareness of the All Wales Flexible Working Policy - The All Wales Flexible Working Policy is accessible to all staff via the Workforce Policies section and the Flexible Working toolkit within the People and Culture area of SharePoint. However, our testing identified that some staff working compressed hours or variable hours had not completed a Flexible Working Request form or submitted a request via ESR for approval by their line manager, as required by the policy. This demonstrates a lack of awareness of the policy requirements.	Corporate Governance - Internal Audit/2026/1107/MD1/2	Introduce a simple standard process for new and existing flexible working arrangements covering request, approval, ESR entry, personal file retention, working pattern confirmation, and leave recording checks.	People & Culture	31/07/2026	Amber	Overdue	01/09/2026			
LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Annual Leave Procedure - An Annual Leave Procedure is in place which is accessible to all staff via the Workforce Policies section and the Annual Leave toolkit within the People and Culture area of SharePoint. The procedure includes guidance on the recording of annual leave, stating that 'when any leave is taken (whether annual of Public / Bank holiday) the contracted hours normally worked on that day should be deducted from the total leave entitlement. This applies in all cases, including where flexible working arrangements (e.g. compressed hours) are in place.' However, our testing identified that staff were not consistently recording annual leave and bank holidays in line with their contracted working hours. Again, this demonstrates a lack of awareness of the policy.	Corporate Governance - Internal Audit/2026/1107/MD2/1	Issue a management briefing on the Flexible Working Policy and Annual Leave Procedure, supported by targeted communications to line managers and staff. Include clear expectations for compressed hours, variable hours, annual leave recording, and bank holiday treatment.	People & Culture	31/07/2026	Amber	Overdue	01/09/2026			
Five Steps to Safer Surgery	Executive Medical Director	22/05/2026	Theatre Whiteboards - Discussions with a range of staff during our theatre visits identified that many staff were unaware of the plan to install 'Team Briefing' whiteboards in every theatre to record step 1 of the WHO Checklist. Most thought they were unnecessary and could not see the benefits of installing them. Review of the proposed whiteboard format identified that there is some overlap between the information currently collected on the Scrub whiteboards and the proposed Team Brief whiteboards. In addition, during our theatre visits we observed that Scrub boards were not being utilised for every surgical procedure or operation.	Corporate Governance - Internal Audit/2026/1084/MD2/1	The white board has been developed by the WHO collaborative in co-production with theatre staff. Staff who opted not to be involved in the WHO collaborative will not yet be fully aware of how this initiative has developed or how it is intended to work. Additional communications and educational sessions will be coproduced and delivered alongside the introduction of the board.	Surgical	31/07/2026	Amber	Partially complete (Overdue)	01/09/2026			Update as part of the WHO Collaborative work remains ongoing and staff will be informed of any updates through all relevant communication channels

Five Steps to Safer Surgery	Executive Medical Director	22/05/2026	Theatre Observations - During our theatre visits, team briefings (step 1) were held at the start of each day, and steps 2, 3 and 4 of the WHO checklist were being carried out for each patient observed. However, the following observations were made during our visits: • Two theatre staff were late for one team briefing and were only present for discussion of the last patient on the list. • The Surgeon was not present for the Sign-out for one surgery observed. It was confirmed in discussions with theatre staff that it was not unusual for Surgeons to leave the theatre before the sign-out. • No de-brief's (step 5) were undertaken during our site visits. We understand that the WHO collaborative, with the support of the Executive Medical Director, determined that Step 5 ("Debriefs") is not mandated but should be undertaken where there is learning to share. However, no records are kept of whether or not a debrief has been requested or held.	Corporate Governance - Internal Audit/2026/1084/MD3/1	All theatre staff will be reminded that the Five steps to safer surgery procedure requires all theatre staff to be present for the team briefing and sign-out stages. This will be done in person at the next upcoming Periop Audit session and will be monitored via the QUAD and tendable audit schedules The new WHO checklist will record whether a debrief has been requested by any member of the theatre team. It is up for the team to decide whether the debrief at the end of the case or at the end of the list. Staff will be asked to fill in a datix if a debrief is requested and does not happen. Medtrim De-briefs are held if significant issues are identified during surgery, and a separate record is kept of these.	Surgical	31/07/2026	Red	Overdue	01/09/2026			
Five Steps to Safer Surgery	Executive Medical Director	22/05/2026	WHO Checklist within Theatre Care Plans - The WHO checklist within each Theatre care plan requires a signature to be recorded for steps 2, 3 and 4. We reviewed 17 Care Plans of patients in the Recovery Area and made the following observation: • Signatures were present for all time-out and sign-out stages, but there were no sign-in signatures for 5/17 care plans.	Corporate Governance - Internal Audit/2026/1084/MD4/1	The new WHO checklist will now capture a name/ Role and signature for the person who has completed that section. This will be audited via QUAD audits and monthly Clinical leader and theatre managers audits on Tenable.	Surgical	31/07/2026	Amber	Overdue	01/09/2026			
Medicines Management	Executive Medical Director	24/06/2026	Incidents and risks remaining open for an excessive length of time - Our review of the Datix reports for the sample wards from April 2025 indicated that a small number of medicine related incidents and risks had remained open for an excessive length of time. Specifically, one ward included two incidents, and a second ward included one incident which had been open for an excessive amount of time without adequate investigation and follow up having been undertaken.	Corporate Governance - Internal Audit/2026/1124/MD4/1	Ward Managers will be reminded that adequate investigation of medicine related incidents and risks must be undertaken as soon as possible so that they do not remain open for an excessive amount of time.	Clinical Diagnostics & Therapeutics	31/07/2026	Amber	Overdue	01/09/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Displaying of Nurse Staffing Levels on wards - We reviewed 15 wards to ensure that the nurse staffing levels were being displayed and identified the following issues: • Wards A7, A5 and B4 - These wards had no nurse staffing level information displayed. • Ward B7 - This ward displayed information that was outdated, referencing a Board presentation date of May 2025. • Wards A6 and A4 - These wards displayed templates where the date last presented to the Board was left blank. • Wards B7, A6 and A4 - These wards displayed information in English only, contrary to Welsh Language Standards and statutory guidance requiring bilingual presentation. • Wards B7, A6 and A4 - These wards had not displayed the number of nurses and healthcare/nursing support required for day-to-day care, however it must be noted that these wards appeared to be using outdated templates.	Corporate Governance - Internal Audit/2026/1129/MD4/6	Action 6 – Ongoing Monitoring and Assurance - Compliance with nurse staffing display requirements will be incorporated into routine nursing quality checks and governance processes. • Follow-up assurance will be reported through nursing governance structures. • A re-audit will be undertaken to confirm sustained compliance across ward areas using Tendable.	Corporate Nursing	31/07/2026	Amber	Overdue	19/05/2026			

LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Annual Leave - We reviewed a sample of 40 employees to establish if annual leave for 2025/26 had been requested correctly, and identified the following findings: • Five employees working compressed hours, and therefore longer days than the standard 7.5 hours a day, were requesting only 7.5 hours of annual leave. As a result, they would exceed their annual leave entitlements by requesting fewer hours than they actually work. • One employee contracted to work 18 hours over two 9 hours days, recorded four instances where only 16.5 hours of annual leave was requested instead of the full 18. • Four employees were not recorded on Healthroster, and no annual leave was documented on ESR. Therefore, it was not possible to determine where their annual leave was being recorded or whether the amounts requested were correct. • One employee had recorded only 240 hours of annual leave on ESR for the full year. Issues were identified in the annual leave	Corporate Governance - Internal Audit/2026/1107/MD6/1	Complete a focused review of staff on compressed hours to identify cases where annual leave or bank holidays have been recorded incorrectly. Correct records prospectively and, where appropriate, agree a fair approach to historical adjustments in line with People and Culture advice.	People & Culture	31/07/2026	Red	Overdue	01/09/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	The Health Board may wish to introduce simple, easy-to-complete activity and demand templates for core services (such as clinics, theatres and hot-week patterns) to support the next round of job plan reviews. Minimum mandatory fields could be required within Allocate (e.g., SPA justification, DCC categories and prospective cover) to strengthen the consistency of inputs. During the medical e-rostering system's configuration, only the most material elements — including DCC totals and out-of-hours commitments — may need to be mapped initially, with more detailed functionality introduced gradually over time. This approach would improve alignment between planned and delivered activity while keeping workloads manageable across Clinical Boards.	Corporate Governance - Internal Audit/2026/1041/MD6/1	Demand and capacity planning in 2026 will be underpinned by more detail baseline activity analysis. This will provide the opportunity for job planning to be more closely aligned to service need. Clinical Boards will utilise the functionality in the e-job planning (R L Datix) system to produce reports on all activity as part of their yearly job planning cycle.	People & Culture	31/07/2026	Green	Overdue	19/05/2026			
LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Annual Leave - We reviewed a sample of 40 employees to establish if annual leave for 2025/26 had been requested correctly, and identified the following findings: • Five employees working compressed hours, and therefore longer days than the standard 7.5 hours a day, were requesting only 7.5 hours of annual leave. As a result, they would exceed their annual leave entitlements by requesting fewer hours than they actually work. • One employee contracted to work 18 hours over two 9 hours days, recorded four instances where only 16.5 hours of annual leave was requested instead of the full 18. • Four employees were not recorded on Healthroster, and no annual leave was documented on ESR. Therefore, it was not possible to determine where their annual leave was being recorded or whether the amounts requested were correct. • One employee had recorded only 240 hours of annual leave on ESR for the full year. Issues were identified in the annual leave	Corporate Governance - Internal Audit/2026/1107/MD6/2	Establish quarterly audit checks on a sample of staff working compressed or variable hours, reporting compliance levels and exceptions through the relevant management forum.	People & Culture	31/07/2026	Red	Overdue	01/09/2026			

LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Bank Holidays - We reviewed the same sample of 40 employees to establish if annual leave for bank holidays had been requested correctly, and identified the following findings: • Seven employees working compressed hours, and therefore longer days than the standard 7.5 hours a day, were requesting only 7.5 hours for bank holidays. As a result, they would exceed their annual leave entitlements by requesting fewer hours than they actually work. • Four employees had not requested all the bank holidays that they had worked. • Four employees were not recorded on Healthroster, and no leave for bank holidays was documented on ESR. Therefore, it was not possible to determine where their bank holidays was being recorded or whether the amounts requested were correct. As per the annual leave key finding, issues were identified in the bank holidays recorded for four out of seven staff within one specific department included in our sample.	Corporate Governance - Internal Audit/2026/1107/MD7/1	Complete a focused review of staff on compressed hours to identify cases where annual leave or bank holidays have been recorded incorrectly. Correct records prospectively and, where appropriate, agree a fair approach to historical adjustments in line with People and Culture advice.	People & Culture	31/07/2026	Red	Overdue	01/09/2026			
LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Bank Holidays - We reviewed the same sample of 40 employees to establish if annual leave for bank holidays had been requested correctly, and identified the following findings: • Seven employees working compressed hours, and therefore longer days than the standard 7.5 hours a day, were requesting only 7.5 hours for bank holidays. As a result, they would exceed their annual leave entitlements by requesting fewer hours than they actually work. • Four employees had not requested all the bank holidays that they had worked. • Four employees were not recorded on Healthroster, and no leave for bank holidays was documented on ESR. Therefore, it was not possible to determine where their bank holidays was being recorded or whether the amounts requested were correct. As per the annual leave key finding, issues were identified in the bank holidays recorded for four out of seven staff within one specific department included in our sample.	Corporate Governance - Internal Audit/2026/1107/MD7/2	Establish quarterly audit checks on a sample of staff working compressed or variable hours, reporting compliance levels and exceptions through the relevant management forum.	People & Culture	31/07/2026	Red	Overdue	01/09/2026			
Implementation of National IT Systems (WNCR)	Director of Digital and Health Intelligence	25/10/2022	The baseline assessment should be fed into a benefits register, and a benefits assessment and realisation process should be included within the project plan.	Corporate Governance - Internal Audit/2022/266/MD4/1	A benefits register will be developed to record: - Digital skills of nursing workforce - Comparison of documentation completion rates before/after WNCR implementation - Use of WNCR analytics to inform improvement work - Staff feedback - Patient feedback (undertaken by patient experience team) - Cost savings (based on removal of paper documents) - Time savings	Digital and Health Intelligence	03/08/2026	Amber	Partially complete (Overdue)	08/11/2022			July 2024 IA tracker update: June 2024 - Ongoing. Awaiting WNCR roll out January 2025- implementation to UHW beginning. Benefits realisation ongoing and can not be completed until roll out concluded. MSc student undertaking benefits realisation work relating to pressure damage. DHCW have undertaken initial baseline work to support. January 2026: - Digital skills of nursing workforce (completed April 2025) - Comparison of documentation completion rates before/after WNCR implementation (awaiting development of WCNR data feed) - Use of WNCR analytics to inform improvement work (awaiting development of WCNR data feed) - Staff feedback (Complete January 2026) - Cost savings (based on removal of paper documents) (complete by DHCW) - Time savings (completed by DHCW) Feb 2026 - action extended for 6 months until August 2026.

Medical Equipment and Devices	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	09/12/2025	Review of the policy and procedure is significantly overdue - The Health Board's policy and procedure in place covering the management of Medical Equipment and Devices were last reviewed on 2 March 2022, with the next review date due by 31 March 2023, which has now passed.	Corporate Governance - Internal Audit/2025/1046/MD1/1	The Health Board policy and procedure which cover the management of Medical Equipment and Devices will be reviewed to ensure that they accurately reflect required actions and any changes will be communicated to relevant staff.	Clinical Diagnostics & Therapeutics	31/08/2026	Amber	In progress	03/02/2026			
LIMITED - Cyber Security	Director of Digital and Health Intelligence	15/08/2025	Cyber security risk register - The Cyber Security Risk Register (or Information Systems Security Risk Register as the document is titled) lacks important information such as: • Dates of when the risk was added to the register or target dates for completion • Named responsible individuals • Actions taken or planned to treat the risk • It is not clear when updates on progress to treat risks were added, and some risks don't have this information at all. • There is no narrative for why a risk will be tolerated and the decision process behind this is not recorded or escalated. • Some risk descriptions do not describe what could happen, why it would happen or what the impact couldbe. Whilst it is recognised that the plan to migrate the risk register to AMaT has now begun, this will not resolve the issues of missing or incomplete information and work will be required to address the gaps highlighted during the migration.	Corporate Governance - Internal Audit/2025/1047/MD1/1	All high risks have now been migrated onto AMaT which is a specific risk management platform. There are mandatory fields that require information therefore all entries will be fully completed. Medium and low risks and any new risks, will be recorded on AMaT, which will then form the basis of our cyber improvement plan, which will concentrate on those highest risks.	Digital and Health Intelligence	31/08/2026	Red	In progress	02/09/2025			Dedicated bi-weekly technical team meeting now focuses on long standing existing risks, discussing 1) what would need to happen to reduce the risk and 2) the resource required. This is then escalated to the monthly SIRO group where a plan is approved and AMAT is updated. If risk is tolerated then a rationale is provided.
Medical Equipment and Devices	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	09/12/2025	Radiology medical equipment and devices are not accurately recorded on Medusa - We selected 22 Radiology medical equipment and devices at UHW and eight Radiology medical equipment and devices at UHL for verification from the Medusa system: • 11 of the medical equipment and devices at UHW had been decommissioned, replaced or were not still in situ. Furthermore, three of the medical equipment and devices could not be verified as the required serial numbers were not recorded on Medusa. • Five of the medical equipment and devices selected at UHL had been replaced, four in 2023 and one in 2025, and a further medical equipment and device was incomplete on Medusa as it only included the workstation not the radiology equipment. In addition, we selected 10 medical equipment and devices on site at UHW and four medical equipment and devices on site at UHL and checked whether they were recorded in Medusa. Only one of the	Corporate Governance - Internal Audit/2025/1046/MD2/1	The Medical Equipment Policy and Procedure will be amended to correctly reflect the arrangements for federated equipment management and the distinction between capital asset records. Clinical Boards and services have responsibility for managing medical equipment and devices used in their areas. They may use their own systems for this activity as appropriate. Access to Medusa can be granted if required. The Policy and Procedure will incorporate the requirement to record financial assets in Medusa for capital management purposes and mandate that updates from the Finance Dept are notified on a regular basis.	Clinical Diagnostics & Therapeutics	31/08/2026	Red	In progress	03/02/2026			

LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Flexible Working Request Forms - A review of a sample of 40 staff records was undertaken to confirm whether a completed Flexible Working Request (FWR) Form was in place, and whether the requests had been entered onto ESR. Overall, we identified 15 cases where a required FWR form was not in place, and we were unable to confirm management awareness of the arrangements for 5 of these cases. The detailed findings are as follows: • Across the 40 cases reviewed, only seven FWR forms were available, but it was noted that one had been completed at the time of the audit. • For 10 cases, a form was not required as the working pattern was contractual (e.g., part-time), related to retire-and-return arrangements, or driven by service requirements rather than an employee request. • A further eight staff had left the organisation or transferred departments. Two FWR forms however were retrieved from personal files. For the five cases where forms were not provided, no	Corporate Governance - Internal Audit/2026/1107/MD3/1	The following actions will be taken to ensure that Flexible Working Request Forms are completed and retained in all cases where flexible working arrangements, including compressed hours and variable working patterns, are agreed on a permanent or longer term basis: • Policy requirements will be reinforced with managers to ensure all flexible working requests are formally documented using the approved Flexible Working Request Form or ESR workflow. • Managers will be reminded of their responsibility to retain completed documentation on the employee's personal file and ensure ESR records are updated accordingly. • Refresher guidance and signposting to the policy and forms to support consistent application across services. In addition, Management will undertake a retrospective review of all current staff working compressed or variable hours to confirm whether a formal request exists, whether approval is documented, and whether records are held on the personal file and ESR where	People & Culture	31/08/2026	Red	In progress	01/09/2026			
LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Consolidated systems guide for managing pay changes, terminations, and absences - In order to assess whether staff have received adequate training and feel supported in managing staff changes, terminations, and absences, we included several training related questions in the survey referenced in Objective 1. From the survey results of the 17 supervisors, it was identified that: • 59% had watched the SMA app videos. • 44% of respondents considered the available training materials to be sufficient for confidently using all features of the SMA app and Managers Self Service (MSS). • 59% of respondents did not know the distinction between the SMA app and MSS and when each should be utilised. • 72% stated they would benefit from a comprehensive user guide detailing the appropriate use of each system; Health Roster, MSS, and the SMA app for managing staff changes, termination and absences. • The average confidence in submitting staff changes and related tasks was 3.39	Corporate Governance - Internal Audit/2026/1056/MD3/1	A clear, consolidated guide covering Health Roster, MSS, and the SMA app will be developed and distributed to managers and supervisors, clarifying responsibilities and processes for managing pay changes, terminations, and absences. The guide will include step-by-step instructions, screenshots, and troubleshooting tips for managing staff changes, terminations, and absences. This guide will also provide clear direction on when managers should use the SMA app in place of MSS, offering concise instructions about each system's roles, features, and best uses and shared with key staff once completed. Awareness campaigns and targeted communications will be initiated to disseminate this guide and training resources, and supplementary training will be offered where required.	People & Culture	31/08/2026	Red	In progress	19/05/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Introduce a standard set of rostering rules and minimum data requirements across all Clinical Boards to reduce variation and support safe preparation for medical e-rostering system. This should include consistent rota-build standards, clear processes for recording sickness and annual leave, and a basic data-validation exercise to check existing templates before migration. Taking this approach will improve data quality, reduce manual workload, and help ensure the Health Board is ready for the planned August 2026 implementation of the unified medical e-rostering system.	Corporate Governance - Internal Audit/2026/1041/MD3/1	As part of the implementation of Medical HealthRoster, rostering principles will be developed for Resident Doctors initially and then for other grades including Consultants: • Resident Doctors - Foundation, Unbanded Rotas and New Hires (locally Employed) • Resident Doctors – All Other Grades • Consultants & SAS	People & Culture	31/08/2026	Green	In progress	19/05/2026			

Data Warehouse	Director of Digital & Health Intelligence	26/04/2023	Leads for data use should be identified within Clinical Boards in order to facilitate better links with Digital. Lead contacts for each Clinical Board should be defined within Digital, within the constraints of the staff resource available.	Corporate Governance - Internal Audit/2023/290/MD4/1	List of current digital coordinators in clinical boards will be reviewed and gaps identified. D&HI will work with Clinical Boards who haven't nominated a coordinator to demonstrate the benefits of the approach.	Digital and Health Intelligence	31/08/2026	Amber	Partially complete	11/05/2023		Two individuals cannot be aligned to cover all boards and corporate areas so resource will need to be used flexibly.	Feb 2026 - action due date extended 6 months to August 2026 October 2025 - two Business Intelligence Partners came into post in July and September 2025. They are currently aligned to two clinical boards where it is expected the roles will improve links between board and the BI Informatics service, therefore improving prioritisation and delivery of data and support self service use of Power BI and other tools. July 2024 IA tracker update: June 2024 - No update Mar '24 - New business structure4 to support additional reporting being developed to include dedicated BI partners aligned to each Clinical Board (May '24)
LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Recording Flexible Working onto ESR - A review of flexible working records identified weaknesses in the recording and monitoring of requests on ESR. Although 93 staff were recorded on ESR as having submitted a flexible working request, People and Culture management indicated that approximately 526 staff within the Medicine Clinical Board may currently be working a flexible pattern, suggesting that not all formal arrangements are being consistently recorded. Of the 93 requests reviewed, 14 had no outcome recorded and 32 remained recorded as "Pending Decision" despite the original request date exceeding the policy requirement for a decision within 2 months. In addition, ESR records were incomplete in respect of key outcome information: 64 requests had no outcome details entered and 67 did not record the date the decision letter was sent. This is not fully in line with the policy requirement that requests are formally considered and decided within 2 months, and that agreed arrangements and relevant correspondence are recorded on ESR for monitoring purposes.	Corporate Governance - Internal Audit/2026/1107/MD4/1	Line managers will be reminded of the requirement to record all formal flexible working requests and outcomes on ESR, including the decision status, outcome details, decision letter date, and arrangement type (for example, permanent, temporary, informal, or trial). A review of all current flexible working arrangements will be undertaken to ensure ESR records are complete and up to date, and a monitoring process will be introduced to identify requests approaching the 2-month decision deadline and to escalate overdue cases where necessary. In addition, Management will Cleanse ESR records to ensure all requests have a decision status, outcome details, decision date, and arrangement type recorded. Introduce a routine report to identify pending requests approaching or exceeding the required decision timescale.	People & Culture	31/08/2026	Red	In progress	01/09/2026			
Medical Equipment and Devices	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	09/12/2025	Lack of Clinical Engineering oversight of Radiology and HSDU / SSU - The vast majority of audit testing was undertaken with staff in Radiology and HSDU and SSU as Clinical Engineering's involvement with these areas is limited and largely relates to providing support if requested. It does not maintain operational oversight of them. The significant number of issues identified under Objective 2 highlight that an increased level of oversight is required to ensure the appropriate recording and management of medical equipment and devices.	Corporate Governance - Internal Audit/2025/1046/MD4/1	As stated above, CE involvement with areas without significant amounts of CE maintained equipment is limited. It is the service user and owner of the equipment that is responsible for operational oversight and compliance with the policy and procedure.	Clinical Diagnostics & Therapeutics	31/08/2026	Amber	In progress	03/02/2026			

LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Non - Medical Staff Overpayments - A sample of 11 non-medical staff overpayment cases was reviewed across three Clinical Boards, highlighting various reasons for overpayments, including: • Common Causes of Overpayments: Issues include late notification of absences, late termination processing, confusion over system use, delayed management reporting, and errors in pay band assignments. Three cases revealed delays of up to six months before corrections were made. • Training and Process Improvement Needs: Feedback from Managers highlighted a lack of training and uncertainty regarding procedures, both of which contributed to delays and errors. Some overpayments were attributed to missed payroll cutoffs and unclear system responsibilities. These issues were also evident during our testing exercise. • Missed Staff in Post (SIP) Reviews: Many overpayments could have been avoided with regular SIP checks. In four of the eleven cases reviewed, earlier checks would have identified the issue,	Corporate Governance - Internal Audit/2026/1056/MD4/1	Managers will be reminded of their responsibility to submit absence and termination notifications promptly, and compliance will be monitored through regular workforce reporting. Additional training resources and refresher materials will be provided to managers to clarify MSS and SMA responsibilities, payroll cut-off dates, and the correct processes for reporting changes. This will include targeted sessions for areas with identified recurring errors. Monthly SIP reviews will be established between Manager, Senior People & Culture BPs and Senior Finance BPs.	People & Culture	31/08/2026	Red	In progress	19/05/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Take a phased, minimum-standard approach by prioritising core rota elements required for medical e-rostering system's configuration—cycle length, weekend frequency, on-call rules, and rest requirements—while addressing high-risk templates first. Establish simple validation checks and provide central coordination support to Clinical Boards to ensure rotas meet contractual and WTD requirements prior to system upload. This avoids wholesale redesign, reduces workload and accelerates readiness for system migration.	Corporate Governance - Internal Audit/2026/1041/MD4/1	As part of the implementation of the WRDC a working group has been established to review current rotas and work towards setting 'establishments' for resident doctors. During the implementation rota monitoring has ceased to enable teams to focus on rota compliance in readiness for August 2026. Within the WRDC, monitoring is replaced by a Guardian of Safe & Flexible Working (GOSFW) and exception reporting. Again, this will be achieved through using a unified E-Rostering system, where regular reports can be produced.	People & Culture	31/08/2026	Green	In progress	19/05/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Consolidate sickness and annual-leave data into a single Health Board-wide dataset and standardise ESR-based processes across Clinical Boards. This will strengthen visibility of medical workforce availability, enable consistent capacity planning, and support safe preparation for the All-Wales resident doctors e-rostering implementation.	Corporate Governance - Internal Audit/2026/1041/MD5/1	The unified E-Rostering system will require all sickness absence to be recorded in the system. This will ensure that the Single Lead Employer (SLE) receives accurate information for Resident Doctors employed by them.	People & Culture	31/08/2026	Green	In progress	19/05/2026			
LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Medical Staff Overpayments - Six Medical Staff overpayments were reviewed involving late termination, changes, and delayed absence notifications during September–November 2025. Each case highlights specific administrative oversights and communication issues contributing to payment errors. These overpayments were also checked against the Medical Resourcing 'Workforce overpayments Log'. • Two Late notification cases caused overpayment: One case involved unpaid leave being recorded in MSS one month after the absence started, resulting in two payroll deadlines being missed. The responsible manager was unaware of the overpayment. This issue should have been identified during a SIP review. A separate instance where unpaid leave was not entered into MSS led to an overpayment of £13,000. The Directorate Manager and Finance identified this overpayment while reviewing the budget. • Termination processing delays: Two cases related to late terminations. In one instance the doctor was overseas and	Corporate Governance - Internal Audit/2026/1056/MD5/1	The following actions will be undertaken to ensure payroll changes for medical staff are processed accurately and promptly, reducing delays caused by informal or manual communication between clinical departments, Medical Resourcing, and Payroll. • Reinforce clear responsibilities for the Clinical Boards for notifying Medical Resourcing of absences, early resignations and contractual changes. • Produce concise guidance setting out responsibilities between departments and Medical Resourcing. • Issue periodic reminders to departments of payroll deadlines and escalation routes for late changes. We will also consider introducing earlier internal cut off dates for departments to allow validation before payroll deadlines. • Reemphasise to departments the importance of monthly Staff in Post reviews. • All identified Medical Staff overpayments will be recorded consistently on the Workforce Overpayment Log, to support the identification of recurring themes and associated training needs.	People & Culture	31/08/2026	Amber	In progress	19/05/2026			

LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Inconsistent distribution and oversight of Staff Overpayments Dashboards - The Novembers private Audit and Assurance Committee reported that Directors of Operations and Senior People & Culture Business Partners now have direct access to the Overpayments Dashboard, enabling them to view live data to support proactive management and early intervention. While evidence confirms that dashboards were shared by the Senior People & Culture Business Partners for the Medicine and Children and Women Clinical Boards, distribution has been inconsistent across the Clinical Boards. Dashboards were initially issued on a monthly basis at the start of the year but later moved to a quarterly frequency towards year-end. The inconsistency in distribution could be linked to the manual processes involved in enhancing the dashboard's usefulness. Senior People & Culture Business Partners are required to individually assign case reports to "oneup" managers, manually identify reporting lines, and segment	Corporate Governance - Internal Audit/2026/1056/MD6/1	Management recognises the importance of consistent oversight of overpayments and acknowledges the challenges associated with the current manual processes. We will strengthen controls over the distribution across all Clinical Boards by: • Standardising the frequency of dashboard distribution across all Clinical Boards. • Introducing automation, where possible, to reduce reliance on manual data segmentation and case assignment. • Clearly defined responsibilities for reviewing dashboards and evidencing actions taken. • Establishing escalation arrangements where evidence of review or action is not provided within agreed timescales.	People & Culture	31/08/2026	Amber	In progress	19/05/2026			
LIMITED - Staff Overpayments	Executive Director of People and Culture / Executive Director of Finance	30/03/2026	Oversight and governance of staff overpayments at Clinical Board level - We established that Clinical Board level oversight of staff overpayments is inconsistent and insufficiently embedded, limiting effective challenge and assurance. • In the Medicine Clinical Board, we evidenced that salary overpayment information is generated and reviewed periodically. Records indicate these overpayments were addressed at the Medicine Clinical Board Formal Board meeting in August; however, the responsibility for continued monitoring and escalation remains undefined. • Email records for Children and Women highlighted that monitoring was done occasionally, but there is no evidence that salary overpayments was formally discussed at a Clinical Board meeting. As with the Medicine Clinical Board, responsibility for ongoing monitoring and escalation is unclear. • In Specialist Services, no evidence was provided, preventing Audit from obtaining any assurance over governance arrangements.	Corporate Governance - Internal Audit/2026/1056/MD7/1	Clinical Boards will include staff overpayments as a standing agenda item within their Formal Board meetings, supported by regular summary reports and formal action tracking processes to provide assurance for Executives. Each Clinical Board will formally assign clear accountability for the scrutiny, management, and escalation of staff overpayment reports. The nominated lead will be responsible for overseeing management actions, monitoring recovery progress, and ensuring that recurring or systemic issues are escalated in line with agreed governance arrangements.	People & Culture	31/08/2026	Amber	In progress	19/05/2026			
Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Identify and Quantify Systems in Use - The People and Culture Plan 2022-2025 highlights an objective to identify all digital systems currently in use to support with preparing staff to be digitally ready. There is no evidence that this has taken place, and although Digital Services may hold some of this information, there is no evidence of this being shared. Without a full list of digital systems throughout the organisation, it will be difficult to determine the digital training requirements of staff.	Corporate Governance - Internal Audit/2026/1162/MD6/1	1. Agree core role types for use in skills assessment. 2. Map key systems used by role and training offer associated with each system. 3. Develop training framework within the DLA and communication plan.	Digital and Health Intelligence	01/09/2026	Green	In progress	19/05/2026			

LIMITED - Neurodevelopment Services for Adults	Chief Operating Officer	01/05/2026	Triage Assessment - There is no single point of access or service for adult ADHD referrals which instead go to one of the six Community Mental Health Teams (CMHTs). Previously there was no consistency in approach to the referral and the subsequent triage. During the course of our audit a revised SOP has been produced which aims to provide a consistent approach, and which does include a screening of all referrals by a Multi-Disciplinary Team. However, the SOP effectively states that all referrals should be added to the waiting list unless more complex needs are identified in which case the adult would be fast-tracked for an appointment. The reason for this is that those adults who have previously not been added to the waiting list are likely to complain which takes up valuable clinical time in responding to the complaint. The simpler solution is therefore to add them to the waiting list. However, given the policy that only one in ten patients seen in clinic is an ADHD referral (which can even be less than this dependent on local priorities), and the fact	Corporate Governance - Internal Audit/2026/1081/MD1/1	The issue of ever-increasing waiting lists for adult ADHD referrals is one that is impacting all mental health services across the UK with some English NHS Trusts closing their waiting lists. One answer to this issue is a stand-alone service similar to how the Integrated Autism Service is currently run. This could be led by specialist nurses with oversight by clinicians, which will be a more cost-effective alternative than the current service model but will require substantial investment to make in-roads into reducing waiting lists. A proposal along these lines was produced in 2024 and updated in 2025 but has not progressed due to a lack of funding. The Health Board will review whether investing in such a service will be a justifiable option in comparison to its other priorities.	Mental Health	30/09/2026	Red	In progress	19/05/2026			
Local / Shadow IT	Director of Digital & Health Intelligence	13/07/2026	Guidance - Although there is a range of guidance in place for the management of digital items, information governance and security, much of this is out of date and requires reviewing and updating. We also note that there is currently a lack of a succinct summary of requirements for managing digital systems and contracts available to relevant staff and system owners.	Corporate Governance - Internal Audit/2026/1258/MD1/1	D&HI team to review and update guidance to include a quick checklist for system owners / managers and make that available on the internal SharePoint site for all staff to access.	Digital and Health Intelligence	30/09/2026	Amber	In progress	01/09/2026			Further clarity required on what "guidance" means in this context - for example, are we referring to a simple checklist for system owners and managers? This action and associated risk relate to Shadow IT, where departments outside D&HI control and manage their own devices and servers. In practice, most devices require network connectivity, and where those devices are joined to our domain, they are on our managed network with the appropriate D&HI controls in place. Where devices are not managed, they are placed on a DMZ or separate VLAN with no, or very limited, access to the corporate network. For servers on our domain, we have an agreed position with CAV Cyber based on least privilege, meaning administrative rights and access are restricted to the relevant assets and systems only.
Space Utilisation - ADVISORY		10/08/2026	Space Utilisation Policy / Procedures - The UHB does not currently have a policy or procedure that sets out its approach to space utilisation management. Such documents are currently more common in NHS England than NHS Wales. Management may wish to consider developing a proportionate space utilisation policy / procedure, which could bring together strategic principles, utilisation targets, governance responsibilities and reporting arrangements, to support a consistent and transparent approach to managing estate capacity.	Corporate Governance - Internal Audit/2026/1257/MD2/1	The HB Accommodation Working Group will discuss the benefits of developing such a document to support the planning and decision-making process relation to accommodation and space utilisation.	Capital Estates and Facilities	30/09/2026	Green	In progress	01/09/2026			

Medicines Management	Executive Medical Director	24/06/2026	Lapses in medicines storage arrangements - The following lapses were identified during our ward visits: • In one ward, a delivery box of assorted medicines was observed on the floor of the locked treatment room which had not been stored in the designated cupboards. In another ward, the treatment room door was unlocked on our arrival, and one of the medicines cupboards was also unlocked. • In one ward, the controlled drugs cupboard key was kept with the main medicines keys rather than being stored separately. In another ward, the controlled drugs cupboard key was locked inside the main medicines cabinet rather than being held by a senior member of staff. This does not align with the Health Board's Medicines Code, which states that best practice requires controlled drugs keys to be kept separately from non-controlled medicine keys and to remain with the person in charge of the ward or area when not delegated or in use. • In one ward, fridge temperature checks for temperature critical medicines were	Corporate Governance - Internal Audit/2026/1124/MD3/1	- We recently undertook a UHB wide medicines storage audit, this highlighted some areas that require new cupboards for storage. - Staff will be reminded of the importance of ensuring that the main door to the treatment room is locked at all times. - We will ensure that fridge temperatures are being recorded on a daily basis. - We have addressed with senior nursing colleagues and staff of the policy regarding control drugs keys. - For future winter wards we will ensure that staff covering these areas will be provided with UHB standards and expectations for meds storage safety.	Clinical Diagnostics & Therapeutics	30/09/2026	Red	In progress	01/09/2026			
LIMITED - Neurodevelopment Services for Adults	Chief Operating Officer	01/05/2026	Publicly Available Information - Services listed on the Health Board website include the Integrated Autism Service and ADHD services for children. Searching for ADHD services for adults brings up only Freedom of Information requests. None of the 31 services listed under the headings of Adult Mental Health Services mention ADHD in their title. This is due to the ADHD provision for adults not being a standalone service but rather one of the responsibilities of the Community Mental Health Teams. The newly issued ADHD SOP states that: "Neurodevelopmental conditions are not considered mental illnesses in themselves. However, individuals with these conditions are at higher risk of developing co-occurring mental health issues, such as anxiety, depression, or obsessive-compulsive disorder. This overlap can sometimes lead to confusion in classification and care pathways."	Corporate Governance - Internal Audit/2026/1081/MD3/1	information available for adults and their families to assist them if they suspect that they might be suffering from ADHD. Whether or not the Health Board changes the structure and current approach (as noted under Finding 1), it will ensure that there is clear information provided to assist adults and their families who suspect that they might have ADHD.	Mental Health	30/09/2026	Red	In progress	19/05/2026			
Space Utilisation - ADVISORY		10/08/2026	Accommodation Working Group - The AWG terms of reference were last reviewed in 2023 and would benefit from a refresh. This could encompass the observations above in terms of the limited focus of the Group and its reporting responsibilities. We further note that whilst the Group is well represented by Capital, Estates and Facilities members, representatives from some operational areas have not routinely attended in recent months (for example IT, Children & Women's). This may reduce the effectiveness of the Group in representing interests on a UHB-wide basis.	Corporate Governance - Internal Audit/2026/1257/MD3/1	The AWG will review the Terms of reference as suggested.	Capital Estates and Facilities	30/09/2026	Green	In progress	01/09/2026			
Local / Shadow IT	Director of Digital & Health Intelligence	13/07/2026	Cyber Essentials - We noted a number of suppliers without a cyber essentials certification, including the supplier of the Dental system which has been recently upgraded. The specification for this did not include a CE+ requirement and our discussion with Procurement noted that the inclusion of this is reliant on D&HI input and not a standard requirement within specifications for applications.	Corporate Governance - Internal Audit/2026/1258/MD3/1	D&HI– notify procurement of Cyber Essentials Plus as a standard requirement in all contracts. If not possible then this needs to be reviewed by the Cyber group with the SIRO to approve any exceptions and include on the Cyber risk register.	Digital and Health Intelligence	30/09/2026	Red	In progress	01/09/2026			

Infection, Prevention & Control	Executive Nursing Director	22/01/2024	The format and content of the IPC Annual Programme should be reviewed and updated. This should include setting of targets for the number of pro-active audits to be carried out in clinical areas. The Head of Nursing for IPC should also seek Clinical Board input when compiling the IPC Annual Programme and should request each Clinical Board to prepare their own IPC annual plans. The annual IPC Programme should be completed and submitted to the IPC Group for approval every year prior to the start of the year.	Corporate Governance - Internal Audit/2024/307/MD4/1	The Annual IPC Programme is being reviewed and will b presented to the IPCG June 2024/	Corporate Nursing	30/09/2026	Red	Partially complete	06/02/2024			July 2024 IA tracker update: The Annual IPC programme is being reviewed and will be presented to the IPCG June 2024. Oct 2025 update - The annual programme has not yet been developed, we are expecting a revised Code of Practice for IP&C from Welsh Government before Christmas. Once that has been received the annual programme for 2026/27 will be developed to reflect the Code June 2026 - The IP&C Annual Programme is expected to be approved in September 2026 via the Infection Prevention and Control Group.
Occupational Health Services	Executive Director of People and Culture	28/04/2026	KPI's Reporting - While Key Performance Indicators (KPI's) are in place and collated on a monthly basis, at the time of the audit these were only reviewed within the department. There were no formal arrangements for reporting or scrutiny of KPI's through an appropriate People and Culture Directorate governance forum. We do acknowledge that an update report on the Service was submitted to the February 2026 meeting of the People and Culture Committee. We also note that the KPI targets are based on calendar days which could disadvantage the department as it operates on a Monday to Friday working week. Whilst DNA's are recorded on the system, they are not currently one of the KPI's collated / reported.	Corporate Governance - Internal Audit/2026/716/MD4/1	We will ensure that Occupational Health KPI's will be embedded within the Workforce KPI Dashboard and reviewed bi-monthly by the People and Culture Committee. We will research, benchmark, and implement an internal KPI relating to DNA rates. We will also adjust the calendar days approach to KPIs to account for non-working days (Saturday / Sunday / Bank Holidays). For example, a previously used 10 Working Day KPI is now set at 14 Calendar Days.	People & Culture	30/09/2026	Amber	Partially complete	19/05/2026			We have ensured that our KPIs are reflective of calendar days in all of our reporting. Ongoing work is in place to ensure reporting is part of the workforce KPI dashboard and benchmarking for DNA rates is underway
Neurodevelopmental Services – Children	Chief Operating Officer	27/04/2026	Administrative Support - The financial constraints and resulting recruitment freezes have meant that there are gaps in numbers of administrative staff. This results in tasks either not being able to be performed, or by clinical and nursing staff having to undertake the tasks, thus reducing the capacity for direct patient care.	Corporate Governance - Internal Audit/2026/1187/MD4/1	Acknowledging the financial constraints on the Health Board there are opportunities for the service to be delivered more efficiently and cost-effectively, and these will be considered alongside competing priorities.	Children & Women	30/09/2026	Amber	In progress	19/05/2026			
Neurodevelopmental Services – Children	Chief Operating Officer	27/04/2026	Assessment Capacity - The Welsh Government has provided additional non-recurring funding to help ensure that no child in Wales is waiting longer than three years for an assessment by the end of March 2026. To meet this requirement the Health Board estimated that it needed to deliver approximately 1,000 additional assessments and that the funding received from Welsh Government (approx. £800k) was insufficient for this number of appointments. The Health Board approached Welsh Government to increase the funded amount, but no further funding was forthcoming. The Health Board has therefore had to absorb the additional costs (approx. £500k) and should be close to meeting the March 2026 target by a combination of the use of private contractors, weekend waiting list initiatives and outsourcing some assessments to a neighbouring Health Board. This neighbouring Health Board has already met its target through processes that are considered quite lean, and	Corporate Governance - Internal Audit/2026/1187/MD5/1	Acknowledging the financial constraints on the Health Board there are opportunities for the service to be delivered more efficiently and cost-effectively, and these will be considered alongside competing priorities.	Children & Women	30/09/2026	Red	In progress	19/05/2026			

LIMITED - Flexible Working Arrangements for Compressed and Variable Hours	Chief Operating Officer / Executive Director of People and Culture	26/06/2026	Healthroster - Healthroster captures the number of hours and days worked by staff, however, it was identified that a number of departments are not using the system. As a result, it is difficult for managers to verify the actual days and hours employees are working. This was further supported by our testing, which involved emailing Managers to confirm how they monitor and review the staff working compressed hours and variable patterns. The findings were as follows: • 14 Managers confirmed that they monitor employees working patterns to ensure they adhere to their approved days and hours. • Four Managers advised that they were in the process of reviewing the employees' working hours. • Six of the selected employees had left the Health Board, and therefore monitoring was no longer applicable. However, all six employees had not been recorded on Healthroster, with three of these working within the same department. • Ten Managers did not respond to	Corporate Governance - Internal Audit/2026/1107/MD5/1	Require managers to review approved working patterns at least annually and at times of service change, role change, or line management change. Where HealthRoster is in use, it should be the primary source for checking actual patterns; where it is not in use, a local roster or signed working pattern record should be maintained.	People & Culture	30/09/2026	Amber	In progress	01/09/2026			
Risk Management and Board Assurance Framework	Director of Corporate Governance	20/04/2026	Sub-Committee Review of BAF - Whilst there is increased evidence of Board sub-committees reviewing issues that are recorded on the BAF, there remains an inconsistency of approach and a lack of an explicit link back to the strategic risks allocated to each Board committee.	Corporate Governance - Internal Audit/2026/1104/MD5/1	The papers for the sub-committees of the Board will include an extract from the BAF relating to those risks allocated to the individual sub-committee.	Corporate Governance	30/09/2026	Amber	In progress	19/05/2026			
LIMITED - Neurodevelopment Services for Adults	Chief Operating Officer	01/05/2026	Administrative Support - The financial constraints and resulting recruitment freezes have meant that there are gaps in numbers of administrative staff. This results in tasks either not being able to be performed, or clinical and nursing staff having to undertake the tasks, thus reducing the capacity for direct patient care.	Corporate Governance - Internal Audit/2026/1081/MD5/1	Acknowledging the financial constraints on the Health Board there are opportunities for the service to be delivered more efficiently and cost-effectively, and these will be considered alongside competing priorities.	Mental Health	30/09/2026	Amber	In progress	19/05/2026			
LIMITED - Neurodevelopment Services for Adults	Chief Operating Officer	01/05/2026	Management Information - The PARIS system is extremely limited in its use in recording and reporting of ADHD referrals and performance. The system is reaching end-of-life and is unlikely to be available after March 2029. No information on the performance of the Health Board in responding to adult ADHD referrals is currently being included in the Integrated Performance Report, although children's services are included due to this being a Welsh Government requirement.	Corporate Governance - Internal Audit/2026/1081/MD6/1	Acknowledging that the current PARIS system is approaching end of life, and that there are many different service users to accommodate in any replacement system, the Health Board will ensure that where possible, recording and reporting of ADHD information is enhanced so that there is up to date and accurate information on the position with adults waiting for an ADHD assessment.	Mental Health	30/09/2026	Red	In progress	19/05/2026			
Neurodevelopmental Services – Children	Chief Operating Officer	27/04/2026	Management Information - Management information is very limited, and the limitations of the current system make reporting very labour intensive and difficult. Different information needs of Welsh Government and the Health Board means that the same information cannot be used for multiple reporting purposes. The PARIS system is nearing the end of life with the contract due to expire in 2028, although it is likely that the Health Board will be able to agree a one-year extension to March 2029.	Corporate Governance - Internal Audit/2026/1187/MD6/1	Acknowledging that the current PARIS system is approaching end of life, and that there are many different service users to accommodate in any replacement system, the Health Board needs to ensure that where possible, reporting of management information is enhanced and that any internal reporting can make use of the specific reporting requirements of Welsh Government in order to avoid any unnecessary duplication of effort.	Children & Women	30/09/2026	Red	In progress	19/05/2026			

ALAS – Equipment Purchasing and Stock Management	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	13/08/2026	BEST included 37 order items which had been open for 6 weeks or more - BEST includes an items on order summary which indicates the number of weeks each order has been open which, at the time of our review, included 37 items which had been open for 6 weeks or more. We did not see any evidence that action had been taken by management to investigate the reasons for the orders remaining open.	Corporate Governance - Internal Audit/2026/1205/MD3/1	Overdue order items will be followed up and resolved in a timely manner.	Artificial Limb & Appliance Service	01/10/2026	Amber	In progress	01/09/2026			
ALAS – Equipment Purchasing and Stock Management	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	13/08/2026	Weekly stock count variances - Weekly stock count variances are recorded directly against individual stock lines within BEST; however, the information is not routinely summarised or reported. As a result, management may not have visibility of overall stock count trends, recurring variances or areas requiring further investigation.	Corporate Governance - Internal Audit/2026/1205/MD4/1	ALAS will implement a process to summarise stock count variances and report trend information to senior management for review.	Artificial Limb & Appliance Service	01/10/2026	Amber	In progress	01/09/2026			
ALAS – Equipment Purchasing and Stock Management	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	13/08/2026	Staff to be reminded that all stock movements must be recorded in BEST - Physical stock verification testing identified three minor discrepancies across ten parts stock lines tested. Although none of the variances were significant and no issues were identified within wheelchair stock testing, the results indicate an opportunity to strengthen stock recording processes and maintain the accuracy of stock records.	Corporate Governance - Internal Audit/2026/1205/MD5/1	The causes of stock discrepancies will be reviewed and staff will be reminded of relevant stock recording requirements where appropriate.	Artificial Limb & Appliance Service	01/10/2026	Amber	In progress	01/09/2026			
LIMITED - Follow-Ups Not Booked	Chief Operating Officer	14/08/2026	SOPs out of date - The Health Board does not have a current, comprehensive SOP in place for the management of FUNB. Existing guidance is outdated and does not reflect current clinical pathways, digital systems, or evolving models of care such as SOS/ PIFU (See On Symptoms/Patient Initiated Follow Ups) and virtual clinics. As a result, Clinical Boards and Directorates have developed their own local processes, leading to variation in how follow-up patients are identified, recorded, and managed. Sample testing (performed under Objective 2) identified differences in practice across services, including how clinic outcomes are recorded, how follow-up appointments are booked, and how pathways are closed. The absence of a clear and up-to-date SOP is likely a key contributing factor to this variation, as there is no consistent framework setting out expected processes or control requirements.	Corporate Governance - Internal Audit/2026/1121/MD1/1	A Health Board-wide SOP for the management of FUNB will be developed, approved and implemented. The SOP will clearly define end-to-end processes, roles and responsibilities, control points (e.g. clinic outcomes, target date setting, validation), and escalation arrangements. It will be supported by formal training and will be embedded through routine monitoring and governance to ensure consistent application across all Directorates.	TRUSTWIDE	05/10/2026	Red	In progress	01/09/2026			

LIMITED - Follow-Ups Not Booked	Chief Operating Officer	14/08/2026	Reactive Management of FUNB Pathways - Discussions with Directorate Management from Ophthalmology and Cardiology specialties noted that the management of follow up patients is primarily reactive rather than proactive. While reports identifying patients awaiting follow-up and uncashed clinics (clinics where the clinical outcome for appointments has not been recorded in the system) are available, these are not consistently reviewed or actioned due to capacity constraints and competing priorities, particularly the focus on RTT waiting lists. As a result, oversight of follow-up activity is largely driven by periodic validation exercises rather than routine monitoring and control. We were unable to confirm that a consistent approach is in place for tracking, reviewing, or escalating patients awaiting a follow-up.	Corporate Governance - Internal Audit/2026/1121/MD2/1	As part of the development of the FUNB SOP, a structured and routine process for the proactive management of FUNB pathways will be implemented, ensuring that follow-up patients are regularly reviewed, prioritised, and progressed. This will include the introduction of weekly monitoring of FUNB lists at Directorate level, supported by clear reporting on volumes, overdue patients, and outstanding actions. Clear ownership will be assigned for managing FUNB pathways, with defined responsibilities for reviewing lists, taking action, and escalating risks where required. The process will move beyond periodic validation exercises and be embedded as a routine operational control, supported by governance oversight within existing Planned Care forums.	TRUSTWIDE	05/10/2026	Red	In progress	01/09/2026			
LIMITED - Follow-Ups Not Booked	Chief Operating Officer	14/08/2026	Weaknesses in Recording Clinic Outcomes ("Uncashed Clinics") - Our testing of the sampled pathways identified significant weaknesses in the recording and processing of clinic outcomes, commonly referred to as "uncashed clinics." Recording the outcome of an appointment is the key control point that triggers follow-up activity, including booking appointments or closing pathways. However, this process is not being consistently completed. Current arrangements rely heavily on manual clinic outcome forms and inconsistent use of digital systems (such as PMS/COM II). Where clinicians do not complete outcomes fully, or where forms are not returned or processed in a timely manner, administrative teams are unable to progress patient pathways appropriately. This results in delays in booking follow-ups, missed activity, and patients remaining incorrectly on follow-up lists. Despite monitoring arrangements being in	Corporate Governance - Internal Audit/2026/1121/MD3/1	The Health Board will strengthen controls around the recording and processing of clinic outcomes, ensuring that outcomes are completed accurately and at the point of care. A consistent, standardised process will be implemented across all Directorates, with clear expectations for clinicians and administrative staff regarding timely completion and processing of outcomes. Consideration will be given to increasing the use of digital systems, such as COM II, to enable real-time recording and reduce reliance on paper-based outcome forms. In addition, arrangements will be put in place to routinely monitor "uncashed clinics," with clear accountability and escalation processes to ensure outstanding outcomes are actioned promptly. This will support more accurate pathway management and reduce the risk of patients being incorrectly retained on follow-up lists.	TRUSTWIDE	05/10/2026	Red	In progress	01/09/2026			
LIMITED - Follow-Ups Not Booked	Chief Operating Officer	14/08/2026	Follow-Up Pathways Not Embedded in Governance - Planned Care governance arrangements are well established across the Health Board, with regular specialty-level meetings in place to monitor elective care performance. However, testing identified that these forums are primarily focused on RTT performance, particularly long-waiting patients, and do not consistently incorporate follow-up (FUNB) pathways. While follow-up patients may be discussed in limited circumstances, there is no structured or routine review of FUNB cohorts, and reporting does not extend to comprehensive follow-up metrics. As a result, follow-up pathways are not subject to the same level of scrutiny, challenge, or oversight as RTT pathways, limiting assurance that delays in follow-up care are being identified and addressed in a timely manner.	Corporate Governance - Internal Audit/2026/1121/MD5/1	Follow-up performance will be formally incorporated into existing Planned Care governance arrangements. This will include the introduction of standardised reporting on FUNB cohorts, covering volumes, overdue patients, and validation activity, to be reviewed routinely within specialty-level and Clinical Board meetings. Clear expectations will be established for review, challenge, and action, with defined ownership for follow-up oversight. Follow-up performance will be considered alongside RTT metrics to provide a holistic view of patient pathways, ensuring that risks are identified early and managed proactively rather than reactively.	TRUSTWIDE	05/10/2026	Amber	In progress	01/09/2026			

LIMITED - Follow-Ups Not Booked	Chief Operating Officer	14/08/2026	Board-Level Reporting of Follow-Up Performance - Reporting to the Finance and Performance Committee does not provide a complete view of follow-up performance. While a metric is reported on patients delayed by over 100% of their target date (29,682 patients as at April 2026), this represents only a subset of the overall follow-up cohort. A significant number of patients recorded within the system do not have a target date assigned (2,107 patients), meaning they are excluded from this measure and not visible within performance reporting. In addition, sample testing confirmed that a large proportion of pathways recorded as awaiting follow-up are not clinically valid. As a result, reporting is based on incomplete and unreliable data, limiting the Board's ability to fully understand the scale of follow-up demand and associated risks.	Corporate Governance - Internal Audit/2026/1121/MD6/1	Reporting arrangements for follow-up pathways will be strengthened by developing a comprehensive and standardised dataset that provides full visibility of the FUNB cohort. Reporting to the Finance and Performance Committee will include total volumes of patients awaiting follow-up, breakdowns by status (e.g. no target date, within tolerance, overdue), and outcomes of validation activity. Clinical Boards and Directorates will also undertake a review of pathways without target dates, ensuring clinically appropriate dates are assigned or pathways are closed where follow-up is no longer required. This will be supported by routine validation processes and clear accountability for data quality. Reporting will then be aligned to validated data to ensure that oversight is based on accurate and complete information.	TRUSTWIDE	05/10/2026	Amber	In progress	01/09/2026			
Space Utilisation - ADVISORY		10/08/2026	Accommodation Request System - The current accommodation request process is largely manual, with no easily accessible central record of what had been submitted or approved. We also found that forms were sometimes completed with limited information, which reduces the ability for the Accommodation Working Group to make well-informed decisions. To improve this, the UHB may wish to move towards an electronic accommodation request system. A digital approach would allow services to submit requests more easily, ensure the right approvals are captured, and create a central log of all activity. As part of this shift, the proforma itself could be strengthened to gather more quantitative detail e.g. staffing numbers, working patterns, desk and furniture requirements; so that decisions are based on a fuller and more consistent picture We understand the Property Manager has also identified the benefits of such a system, and we would encourage the progression of this to improve management in this area.	Corporate Governance - Internal Audit/2026/1257/MD4/1	The AWG developed the application form which gathers sufficient data to provide the background to the requirements and it is then a matter for the clinical board representative to attend the AWG meeting to answer additional questions from the group to enable a decision to be made. Where CB representation is not made then the Director of Operational planning will advise the panel or refer back to the relevant CB. The consideration proposed as part of the Audit will be discussed at the next AWG meeting.	Capital Estates and Facilities	14/10/2026	Green	In progress	01/09/2026			
Space Utilisation - ADVISORY		10/08/2026	Enhancing Space Utilisation Insights to Support Decision-Making - Noting the limited interaction across relevant forums as noted at Management Consideration 3, management may wish to consider introducing periodic reporting on key utilisation indicators and activity in this area to relevant governance forums, including performance against the aims of the Estates Strategy. This could support improved visibility of estate usage patterns and enable more proactive identification of opportunities for optimisation or reconfiguration.	Corporate Governance - Internal Audit/2026/1257/MD6/1	To be discussed at the next available AWG meeting.	Capital Estates and Facilities	14/10/2026	Green	In progress	01/09/2026			
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	Completion and review of establishment calculations - The testing we undertook, as detailed above, confirmed that all 10 sampled wards demonstrated completion of the required components with the exception of ward A2, where the outcome summary was incomplete. In addition, two wards, C5 and C6, were identified where the establishment documentation had not been signed by designated personnel.	Corporate Governance - Internal Audit/2026/1129/MD1/1	Action 1 - Strengthening Establishment Template Completion and Approval - A revised submission process will be implemented to ensure that all templates are checked using a standardised checklist prior to sign-off review meetings, including confirmation that documentation is signed by the designated personnel.	Corporate Nursing	31/10/2026	Amber	In progress	19/05/2026			

Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	Lack of documented governance control procedure - The Health Board currently lacks documented control procedures that clearly defines the overall governance arrangements for compliance with the Act and statutory Code. Although specific procedures are in place for the management of ALN correspondence that sets out statutory obligations, response protocols, and collaboration requirements, there remains a significant gap in formalising a unified governance and reporting structure. This absence of a documented control procedure means that crucial aspects of governance are undocumented, which may lead to ambiguity in roles and responsibilities. The Health Board have not yet produced a documented governance control procedure as they are awaiting the outcome of the review of the ALN Legislative Framework being undertaken by Cabinet Secretary for Education. It was further evidenced that ALN-related data reporting varies across Health Board teams, making compliance monitoring and escalation less effective. Without	Corporate Governance - Internal Audit/2025/1002/MD1/1	A documented governance control procedure will be developed and approved. The document will: • Clearly define governance structures, roles, and responsibilities for ALN compliance. • Standardise reporting requirements and escalation procedures for ALN-related data across all relevant teams. • Be communicated to all key individuals involved in ALN processes. • Include a schedule for regular review and update, with review dates recorded.	Children & Women	31/10/2026	Amber	In progress	03/02/2026			11/03/2026 - Development of first draft of ALN Governance Policy - for comments with membership of ALN Quarterly Strategic /Operational Update meeting
Speaking Up Safely	Director of Corporate Governance	23/07/2026	SUS Guidance – Absence of Welsh Government SUS Framework Timescales - The Health Board Speaking Up Safely Guidance states the processes undertaken when a SUS concern is raised. However, it does not include the process timescales as prescribed in the Welsh Government SUS Framework. Including these timescales within the SUS Guidance would provide individuals raising concerns with a clearer understanding of the process and greater confidence that their concerns will be reviewed and addressed in a timely and efficient manner. SUS Guidance for Welsh language speakers - We note that the Guidance is not currently available in Welsh, nor is there supplementary information stated on the respective SUS Sharepoint and internet sites that signposts Welsh language speakers to report their concerns in the medium of Welsh.	Corporate Governance - Internal Audit/2026/1195/MD1/1	The Health Board Speaking Up Safely (SUS) Guidance will be revised to state the Welsh Government case processing timescales. The Corporate Governance Department will liaise with the Health Board Welsh Language Officer to facilitate the translation of the SUS Guidance into the medium of Welsh and ensure appropriate Welsh language signposting is provided on the respective Sharepoint and internet SUS pages.	Corporate Governance	31/10/2026	Amber	In progress	01/09/2026			
Speaking Up Safely	Director of Corporate Governance	23/07/2026	Absence of a planned SUS awareness Programme - Currently there is no formal, structured and planned programme of ongoing awareness/engagement activities designed to systematically cover all Clinical Board Directorates, thereby maximising awareness of the SUS agenda, the SUS Sharepoint site and the Work In Confidence reporting platform.	Corporate Governance - Internal Audit/2026/1195/MD2/1	The Corporate Governance Department will compile a formal and timetabled programme of SUS awareness/engagement events that will cover all Clinical Board Directorates.	Corporate Governance	31/10/2026	Amber	In progress	01/09/2026			
Smoking Cessation	Executive Director of Public Health	06/12/2024	Absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board	Corporate Governance - Internal Audit/2024/852/MD2/1	Work will be undertaken collaboratively between the Hospital Smoking Cessation Service and Public Health Team to increase and improve the level of awareness of smoking cessation support available via electronic mediaacross the UHB for patients, staff and visitors. In addition,more Smoking Cessation promotional resources will be placed on display within public, clinical and Ward based settings.	Public Health	31/10/2026	Amber	Partially complete	04/02/2025			Promotional activity underway across all hospital sites

Leadership and Management Training / Development	Executive Director of People and Culture	28/05/2026	Reporting of training Programme progress delivery and outcomes - Currently there has been no routine reporting of activity, progress delivery and course feedback evaluation in respect of the two non-clinical Learning and Management Programmes (First Steps to Leadership & Management and Essential Leadership & Management Skills) since November 2025. Performance reporting of the Education Team's Clinical Leadership and Management Programmes cannot currently be undertaken, as two of the three Programmes do not commence until April 2026. In addition, the ELEV8 Programme concluded in early April 2026, and therefore no outcome analysis has been undertaken in respect of this Programme. However, we note that plans are in place for future reporting of all clinical and non-clinical Programme activity on a quarterly basis to the Executive Director of People & Culture, with the intention that Programme activity and delivery outcomes will be subsequently reported to the People and Culture Committee.	Corporate Governance - Internal Audit/2026/1120/MD3/1	Regular and formal progress reporting in relation to their respective programmes will be provided by the Head of ECOD and Head of Leadership and Management to the Executive Director of People & Culture. In addition, bi-annual reporting on programme progress and course completion outcomes will be submitted to the People and Culture Committee.	People & Culture	31/10/2026	Amber	In progress	01/09/2026			
Speaking Up Safely	Director of Corporate Governance	23/07/2026	ESR SUS Training for staff and managers - Currently, SUS specific training is available to staff and managers via three non-mandatory ESR training Modules, these being: • Speak Up – Core training for all staff; • Listen Up – Training for all Managers; and • Follow Up – For Senior Managers Our review of ESR data relating to the uptake of these Modules between the launch of SUS in December 2024 and June 2026 identified limited engagement. During this period, 12 Health Board staff completed the Speak Up – Core training for all staff module, while no Health Board managers have completed the Listen Up – Training for all Managers module and the Follow Up – For Senior Managers module. Given the very low course completion rates, there is a clear opportunity to increase awareness and promotion of these Modules to support greater uptake of SUS training across the Health Board. We noted that none of the three ESR SUS Modules are referenced or signposted on	Corporate Governance - Internal Audit/2026/1195/MD3/1	The ESR SUS Modules will be signposted on the SUS Sharepoint site, referenced within future iterations of the SUS Guidance and their existence promoted as part of future SUS awareness exercises. It is noted this will support with raising awareness and promoting a speaking up safely culture in the UHB and be used in parallel with Connector training.	Corporate Governance	31/10/2026	Amber	In progress	01/09/2026			
Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	ALN Champion role and responsibility - The Terms of Reference (ToR) for the Additional Learning Needs Implementation Operational Group (ALNIG) describes the roles of ALN Champions in carrying out the ALNET Act 2018 within their departments or services. The ToR highlights the importance of sharing information effectively, ensuring compliance, working together across health boards, raising concerns when needed, involving professional groups, and understanding legal responsibilities to help guide decisions and develop staff. While the ToR outlines certain aspects, there remains a lack of clarity relating to training, development, and the specific expectations for ALN Champions. Additionally, several recurring themes and concerns emerged from the survey responses provided by ALN Champions regarding their understanding of their roles. The feedback provided was as follows: • There is confusion and inconsistency	Corporate Governance - Internal Audit/2025/1002/MD3/1	ALN Champion roles, responsibilities, and expectations will be clearly defined and communicated to prevent gaps in accountability or process ownership.	Children & Women	31/10/2026	Green	In progress	03/02/2026			10/02/2026 - discussion of draft version 1 paper ALN Champions - Expectations, Roles and Responsibilities at ALNOG meeting. Request for feedback from membership. 10/02/2026 - review of CaV ALNOG ToR. Request for feedback from memebrship. 18/03/2026 - launch of CaV ALNOG membership survey 16/04/2026 - discussion of draft version 2 paper ALN Champions - Expectations, Roles and Responsibilities at ALNOG meeting. Request for feedback from membership. 16/04/2026 - discussion of draft version 2 ALN Governance Policy' - inclusion of ALN Champions - Expectation, Roles and Responsibilities at ALNOG meeting. Request for feedback from membership. 16/04/2026 - discussion of ALNOG membership survey feedback to inform review of CaV ALNOG ToR. 08/07/2026 - Finalise CaV ALNOG ToR - removal of the term 'Champions'.

Local / Shadow IT	Director of Digital & Health Intelligence	13/07/2026	Record of Systems - There is no complete, accurate record of what digital systems and suppliers are in use across the whole organisation and no assessment of criticality, no completion of CAF assessments outside of D&HI and no assessment of the risk that suppliers present.	Corporate Governance - Internal Audit/2026/1258/MD4/1	- DH&I - Formulate a mail to senior managers requiring staff to complete the form with information on all their digital applications. - Update the central Info Assets Register based on the information received - Issue formal communication from Dir D&HI asking for details on digital application with a clear statement that managers must comply with the request.	Digital and Health Intelligence	31/10/2026	Amber	In progress	01/09/2026			
Local / Shadow IT	Director of Digital & Health Intelligence	13/07/2026	Risk Recording - There is a wide range of software in use, with some breaching HB Policy and WG requirements. Despite management of these being devolved, these risks are not being recorded within departmental risk registers and so the true risk to the Health Board is unquantified.	Corporate Governance - Internal Audit/2026/1258/MD5/1	- Cyber team to issue guidance on the NIS/CAF/WG requirements relating to systems and software in use. - All CBs and corporate services to assess their systems and include on Risk Register where appropriate. - Linked to above, where the information identifies non compliance, these should be collated into a report for the Cyber group to review. Notification to be provided to departments manging these systems to include on their risk registers.	Digital and Health Intelligence	31/10/2026	Red	In progress	01/09/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Introduce a single monthly dashboard covering sickness (ESR + SLE feeds), and annual leave utilisation, using simple metrics and RAG ratings to improve visibility without creating administrative burden.	Corporate Governance - Internal Audit/2026/1041/MD8/1	Once the e-rostering system has been implemented for the Resident Doctors, a dashboard will be developed using data from the systems available to us, in a similar way to other staff groups.	People & Culture	31/10/2026	Green	In progress	19/05/2026			
Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Leveraging the Positive Work Already Underway or Completed - Positive digital literacy/capability work is already taking place across the organisation, including locally delivered M365 training that received excellent staff feedback, and the clinician-to-clinician support model used in the ePMA and WNCR rollouts. These approaches have proven effective in building digital confidence, strengthening clinical relationships, and supporting successful adoption. The value of the clinician-led enablement is recognised within the Digital Foundations Business Case. The planned Digital Capability Project/Workgroup should build on this momentum by exploring how these locally effective models can be retained and scaled, and by ensuring that the staff who delivered them are directly involved in shaping future organisational approaches to digital literacy/capability.	Corporate Governance - Internal Audit/2026/1162/MD8/1	1. Modelling activity to understand local and clinician led approaches and potential and capacity for spread and scale activity. 2. Scope digital capability and literacy needs of UHB staff working in dedicated education roles and explore development of expertise within these roles to support awareness raising. 3. Develop a sustainability plan to retain expertise and engagement post organisational assessment. Explore potential for development of a Digital Champions Network.	Digital and Health Intelligence	01/11/2026	Green	In progress	19/05/2026			
Reducing Health Inequalities - UNSATISFACTORY	Executive Director of Public Health	17/08/2026	No training or guidance for staff on patient ethnicity data collection - The Health Board has not developed or delivered specific training or provided guidance for staff involved in collecting, recording, or handling patient ethnicity data or other protected characteristics.	Corporate Governance - Internal Audit/2026/1091/MD2/1	Management will develop targeted guidance for frontline and administrative staff on the importance and appropriate techniques to collect protected characteristics including ethnicity data within the Health Board. The guidance will then be sign posted as part of the Equality, Diversity and Human Rights training module. Each Clinical Board will have visibility of the percentage of their staff who are compliant with the mandatory Equality, Diversity and Human Rights training.	Public Health	30/11/2026	Amber	In progress	01/09/2026			
Local / Shadow IT	Director of Digital & Health Intelligence	13/07/2026	Governance - As noted in our previous report on Cyber Security there is a feed into the wider organisation from DIC, however there is no representation from Clinical Boards and the Chief Operating Officer does not attend, as such there is limited visibility and accountability over how devolved digital items are managed and overseen.	Corporate Governance - Internal Audit/2026/1258/MD2/1	- D&HI - Continue to work to feed in. - Extend invitation for COO or nominated CB lead to sit on the Digital & Infrastructure committee of the board. - Establish a Teams channel for owners. - Formally communicate that the D&HI team are the professional leads and that guidance must be followed. - Seek endorsement from SLT to require the identification of all - DDAT systems / owners to join Teams channel.	Digital and Health Intelligence	30/11/2026	Amber	In progress	01/09/2026			

Reducing Health Inequalities - UNSATISFACTORY	Executive Director of Public Health	17/08/2026	Absence of clear ownership and accountability for ethnicity data collection - The Health Board has designated Board Champions for each of the protected characteristics. The Chief Executive is the Board Champion for ethnicity.	Corporate Governance - Internal Audit/2026/1091/MD4/1	Management will: • Reinstate and refresh the Board Champion role expectations for ethnicity and other protected characteristics across the Executive Team with clear objectives and tasks assigned as part of the Champion role.	Public Health	30/11/2026	Red	In progress	01/09/2026			
Space Utilisation - ADVISORY		10/08/2026	Work Plan - Recognising the Property Manager was relatively new in post, it may be beneficial to produce a 'work plan', centralising detail such as goals, targets, timeframes, planned activities etc. across a specific time-period e.g. annual/three-year look ahead. This may assist in the prioritisation of activities, identification of any additional resource requirements etc. and may aid in the monitoring and reporting of progress/achievements in space-related activities.	Corporate Governance - Internal Audit/2026/1257/MD5/1	The Head of Estates & Facilities will work with the property manager to develop a work plan to include objectives, outcomes and target dates for consideration by the CMG and ongoing monitoring.	Capital Estates and Facilities	30/11/2026	Green	In progress	01/09/2026			
ALAS – Equipment Purchasing and Stock Management	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	13/08/2026	Analysis of average lead time by supplier report includes multiple error messages - The analysis of average lead time by supplier report provided by NWSSP Procurement includes multiple #VALUE! error messages rather than the number of days lead time which occurs if any of the orders are not delivered until after the period end.	Corporate Governance - Internal Audit/2026/1205/MD1/1	ALAS will work with NWSSP Procurement to ensure supplier lead time reporting is accurate, complete and capable of supporting effective monitoring of supplier performance.	Artificial Limb & Appliance Service	01/12/2026	Amber	In progress	01/09/2026			
Standards of Business Conduct	Director of Corporate Governance	17/12/2025	Insufficient Staff Communication on Declaration Requirements - Staff are advised on requirements regarding interests, gifts and hospitality within the policy and procedures; however, communication and reinforcement mechanisms are not sufficient. • Communication was limited to the Independent Members who received email notifications when declarations for the year end were due for updating • There was no initial, reminder or routine communication sent to all staff ahead of the 2024/25 end of year declaration. • Posters referenced outdated paper forms. • Awareness activities, such as screen savers were acknowledged but not evidenced.	Corporate Governance - Internal Audit/2025/1057/MD1/1	• Update the posters to align with the current electronic completion form on ESR for declaring their interests. • Update the communication plan to confirm the communications that will be utilised for enabling staff to declare their interests.	Corporate Governance	31/12/2026	Amber	In progress	03/02/2026			
Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	Identifying and maintaining ALN training records - DECLO led training attendance records are not maintained. As a result, it has not been possible to determine whether the training sessions were well attended. The absence of such records limits the ability to assess the level of staff engagement and participation in the training provided. In addition, we were informed by the DECLO that it is the ALN Champions responsibility for identifying individuals within their areas who require ALN training and that this identification process should be integrated into the annual appraisal cycle. However, it was also identified that three out of the eight ALN Champions had not accessed training on ALN. Furthermore, ALN Champions should maintain accurate records of both those staff members who have completed ALN training and those who require further development in this area.	Corporate Governance - Internal Audit/2025/1002/MD2/1	For DECLO led ALN training, attendance logs will be kept and shared with the relevant ALN Champions. Heads of Service/Department/Medical Specialty supported by their ALN Champions will establish via the annual VBA cycle, the ALN related training needs of their staff, which will be included in the 'Service-wide' training needs registers. This training will include accessing national training videos, internal supervision and training as well as DECLO led training. ALN related training needs will be shared with the DECLO to help inform the focus and content of future DECLO led training. Heads of Service/Department/Medical Specialty supported by their ALN Champions will monitor the attendance of and completion by their staff of ALN training, thus ensuring that all staff are ALN competent as relevant to their role.	Children & Women	31/12/2026	Amber	In progress	03/02/2026			11/03/2026 - Process established for the maintaining of attendance logs for DECLO led ALNET Act training for staff and the informing of Heads of Service/Department/Medical Specialty and their ALN Champion of attendance by their staff. (see attachment ALNET Act Training SOP v3). 11/03/2026 - ALN Governance Policy - Responsibility Section will include reference to 1) maintaining and sharing of training attendance record by the DECLO 2) including of the raising of ALN awareness and competence within the existing VBA/appraisal processes by Heads of Service/Department/Medical Specialty and 3) the sharing of identified ALNET Act related training needs by the Heads of Service/Department/Medical Specialty to the DECLO

Risk Management and Board Assurance Framework	Director of Corporate Governance	20/04/2026	Data Cleansing - The migration of risks onto the AMaT system is largely complete and some directorates have taken the opportunity to review the information recorded to ensure that it remains both current and relevant. However, other areas of the Health Board have not thus far taken this opportunity and with approximately 1500 risks on the system it is important that any out-of-date, irrelevant or duplicated information is removed where possible. We acknowledge that the Health Board are aware of this need and have set a deadline of the autumn of 2026 to achieve it.	Corporate Governance - Internal Audit/2026/1104/MD2/1	All risks on AMaT will be reviewed to ensure that they remain relevant and current, and oversight of completion of this action will be undertaken by the newly established Organisational Risk Management Group. The Senior Leadership Team are to undertake a moderation of operational risks by the end of Q3.	Corporate Governance	31/12/2026	Amber	In progress	19/05/2026			July 2026 - risk moderation is currently underway across clinical boards and corporate teams. Corporate governance have spoken to all clinical boards to requests risks are reviewed, especially risks scoring 20+. Support has been given to teams to utilise the filtering functionality on AMAT to inform risk moderation discussions. Teams are able to pull reports on their most likely risks occurring to determine if they are happening or not. There is also a risk reporting video being produced which will assist teams with how they can pull reports off AMAT to aid with discussions and decision making across their areas. A risk moderation discussion is scheduled for SLT in Q3 and all CBs are aware of this and conducting their risk moderations in advance of that discussion. The First Organisational risk management group meeting is scheduled for the 23 July 2026 where the TORs will be agreed with the group and then subsequently agreed by SLT in August 2026.
Nurse Staffing Levels	Executive Nurse Director	05/05/2026	SafeCare completion - Review of a sample of 10 wards identified that, while SafeCare input was generally completed within the required parameters, a number of compliance issues remained. The E-rostering Project Manager advised that an agreed compliance threshold of greater than 90% for completion of the SafeCare census is in place, as set out within the Rostering Principles. Analysis of SafeCare completion data across the sampled wards over a sixmonth period identified the following: • Overall SafeCare completion averaged 93% for daytime entries and 90% for night-time entries. • Ward B7 demonstrated lower levels of compliance, with average completion rates of 84% during the day and 72% at night. • Ward C5 recorded a morning completion rate of 82%. • Ward B6 recorded a night-time completion rate of 86%. • Ward B5 recorded a night-time completion rate of 87%. • Ward A2 recorded a night-time	Corporate Governance - Internal Audit/2026/1129/MD2/2	Action 2- Monitoring and Re-audit of SafeCare Compliance - Compliance will be monitored through routine productivity and performance review meetings at Director of Nursing and Clinical Board level. Reaudit compliance at three and six months to determine if targeted improvement actions are required for areas where compliance remains low.	Corporate Nursing	31/12/2026	Amber	In progress	19/05/2026			
Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Creating a New Digital Literacy Assessment - If it is decided to create a new digital literacy assessment, it should consider: • Identifying core competency areas, such as basic IT skills, information literacy, cyber security awareness, and any specialised skills. • Defining baselines, requirements, and targets for staff by role, aligned to the competency areas above to ensure relevance • Tailor the assessment to the staff members role, so that questions are relevant. • Mandating completion of the assessment (for example, through the PADR or induction process). • Ensuring the assessment is time-efficient to complete. • Involving staff from across the organisation in testing the assessment and provide a clear feedback channel for changes to be suggested, helping to avoid issues experienced with the HEIW DCF self-assessment. • Automating the issuing, chasing and collecting of the results to reduce the time	Corporate Governance - Internal Audit/2026/1162/MD3/1	1. Explore existing NHS Wales assessment methodologies as per section 1. 2. Explore the use of JISC with Cardiff and Vale College. 3. Finalise approach and project plan development with DLA Faculty as per section 1.	Digital and Health Intelligence	31/12/2026	Green	In progress	19/05/2026			

Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	Documented Strategy and Joint work plan - Within the South-Central region, a collaborative Regional Health ALN Implementation Plan 2021-22 was developed to support ALN implementation. An overarching strategy document was not produced, as the Implementation Plan served this purpose. However, this plan focused mainly on operational tasks and planning instead of broader strategic goals. The Implementation Plan, initially drafted in May 2021, outlines six priorities, each supported by a range of objectives (17 in total). At present, it remains uncertain whether full implementation of the project plan has occurred in accordance with the 2024 deadline. We were informed that there were plans for a new joint work plan with education partners, however this has not progressed as shared ownership was lacking and much responsibility fell to the DECLO. Task and finish groups existed, but without agreement or shared leadership, a	Corporate Governance - Internal Audit/2025/1002/MD5/1	As per ALN legislative review recommendation, one of the WG recommendations is for RPBs to help promote a whole-systemapproach to improve multiagency, integrated population planning, accountability and delivery for school aged children and young people with Additional Learning Needs. In addition, as in line with the RASG ToR, a joint work plan will be developed with clear shared ownership between health and education partners, ensuring responsibilities do not fall disproportionately on the DECLO.	Children & Women	31/12/2026	Amber	In progress	03/02/2026			10/25 - 02/26 - Discussions with the Programme Manager - Regional Partnership Board - Re recommendations from ALN Legislative Review re the role of the RPB, the spotlight event on 04/12/25, and expectations of RPB re CYP with ALN (see attachment CaV Paper for Strategic ND Board 23/10/25). 15/01/2026 - Regional ND Strategic Board - Agenda item: Supporting Additional Learning Needs and the Importance of Education in the Whole System - Presented Paper - see attachment CAV Paper for Strategic Board 23/10/25.
Reducing Health Inequalities - UNSATISFACTORY	Executive Director of Public Health	17/08/2026	Ethnicity data collected in isolation and not integrated for strategic use and limited use in reporting - Ethnicity data is collected across various sources (e.g. GP registrations, patient experience surveys, immunisation systems, Outpatients, Inpatients, Day Cases, Regular Day Attendances, and Emergency Unit); however, it remains siloed and is not integrated into a single unified, analytical view. While surveys such as Civica collect voluntary equality data, their primary focus is on service satisfaction. Although the survey ethnicity data is collected, analysed and provided to Clinical Boards on a weekly basis, it is not consolidated to support broader monitoring or strategic reporting of the data beyond the routine reports issued to the Clinical Boards. Patient ethnicity data is currently not monitored or reported within the Health Board governance structures. Reviews of Quality Committee and People and Culture Committee papers showed no reference to patient ethnicity monitoring or reporting during the last 9-month period reviewed.	Corporate Governance - Internal Audit/2026/1091/MD5/1	Management will direct the Clinical Boards to undertake reporting and review of routine data with a focus on ethnicity and other protected characteristics as a standard part of any reporting.	Public Health	31/12/2026	Red	In progress	01/09/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Consolidate sickness and annual-leave data into a single Health Board-wide dataset and standardise ESR-based processes across Clinical Boards. This will strengthen visibility of medical workforce availability, enable consistent capacity planning, and support safe preparation for the All-Wales resident doctors e-rostering implementation.	Corporate Governance - Internal Audit/2026/1041/MD5/3	The system will also enable us to develop dashboards using the data for locally employed doctors (LEDs), R/D employed by SLE, along with SAS and Consultants.	People & Culture	31/12/2026	Green	In progress	19/05/2026			

Additional Learning Needs (ALN)	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	02/12/2025	Process Mapping and future impact - The Health Board has not assessed future ALN demand due to ongoing system changes. However, SLT responded to the Senedd committee questions on behalf of the Royal College of Speech & Language Therapy submission on ALN and its impact. Key findings from the responses are provided below. The ALN system has improved shared understanding and collaboration between families and staff but significantly increased workload and service challenges. Staff regularly handle tribunal counterarguments, a high number of dispute resolutions. Between September 2024 and July 2025, there were 49 S65 information requests, 17 S65 help requests, 18 S20 referrals, and 248 PCP meetings for SLT. For context, PCP meetings take at least 2 hours. Occupational Therapy estimates that when support is requested by the LA (via multiple s65 for the same child) in relation to a forthcoming Education	Corporate Governance - Internal Audit/2025/1002/MD6/1	Services will conduct a formal evaluation of future ALN demand and required resources.	Children & Women	31/12/2026	Amber	In progress	03/02/2026			
Reducing Health Inequalities - UNSATISFACTORY	Executive Director of Public Health	17/08/2026	There is potential that data could be linked between either primary and secondary care or via Secure Anonymised Information Linkage data set (SAIL) that would improve the data quality and coverage of ethnicity and other protected characteristics, this would improve data quality.	Corporate Governance - Internal Audit/2026/1091/MD6/1	- Management will investigate the option of data sharing between primary and secondary care of protected characteristics data. - Management will investigate the linking of data via the Secure Anonymised Information Linkage data set (SAIL) - All newly developed patient related systems will include questions on protected characteristics, and input controls to ensure these are completed before patients can proceed to the next stage.	Public Health	31/12/2026	Red	In progress	01/09/2026			
ADVISORY - Medical Staff Deployment	Executive Medical Director	27/03/2026	Strengthen engagement by using short, focused clinical–corporate workshops, appointing clinical champions for each workstream, and issuing regular "you said → we did" updates to build visibility and trust.	Corporate Governance - Internal Audit/2026/1041/MD9/1	The Medical & Dental senior leadership team and the Executive team, supported by the People & Culture team will continue to improve the communication and engagement across the UHB, via the LNC and SMSC. • A new Clinical Director and peer support programme is in development which will support improved engagement. • A Health Care Professional Forum is also being scoped out. • Corporate Induction is being strengthened along with a dedicated induction for Consultants.	People & Culture	31/12/2026	Green	In progress	19/05/2026			
Wellbeing Hub at Park View		01/05/2026	Revenue Model - The draft FBC initially included a recurring £0.624m additional annual revenue requirement, which compares with £0.676m approved within the OBC. The revenue requirement had in fact therefore slightly reduced. When the FBC revenue case was presented to the Value and Benefits Group and Finance & Performance Committee in July 2025, it was rejected over concerns it did not adequately demonstrate how the new facility would deliver operational efficiencies and did not achieve financial sustainability. The failure to achieve timely approval of the revenue model delayed the timeline for submitting the FBC to the Board and then WG. Board approval was subsequently achieved on 27th November 2025, following further work to reduce the additional annual revenue costs, which now stand at £334k per year. The UHB should reflect on the approach taken and consider how processes can be	Corporate Governance - Internal Audit/2026/1186/MD10/1	There will be a lessons learnt review applied to the project to identify any lessons for the benefit of future projects, in respect of understanding and communication of the revenue model expectations of the Board/Executives, between business case stages.	Finance	31/12/2026	Amber	In progress	19/05/2026			

ALAS – Equipment Purchasing and Stock Management	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	13/08/2026	Delays in handing over equipment to patients - We tested a sample of 10 equipment purchases and identified delays between receipt of equipment and handover to patients in all cases reviewed. Delays ranged from one month to five months and included cases where equipment had not yet been issued to the patient at the time of testing. The reasons for delays were not consistently documented and there was limited evidence of management monitoring of the period between receipt and patient handover.	Corporate Governance - Internal Audit/2026/1205/MD2/1	Clinician workflow and resource capacity will be reviewed to minimise delays in handing over equipment to patients. Reasons will be consistently documented for any future delays and ongoing monitoring will be undertaken to ensure the number and length of delays are minimised.	Artificial Limb & Appliance Service	01/01/2027	Amber	In progress	01/09/2026			
Medical Equipment and Devices	Executive Director of Allied Health Professionals, Health Scientists and Community Services Development	09/12/2025	Overdue planned maintenance dates - One of the Agreed Management Actions in our previous audit was that Clinical Engineering would perform an audit of items not seen for over 10 years. However, while a Medusa online dashboard has since been developed to help facilitate this, we note that it lists a significant number of assets with overdue planned maintenance dates. It was identified that: • four were due in 2016; • two were due in 2018; • four were due in 2019; • six were due in 2020; • 58 were due in 2021; • 240 were due in 2022; • 320 were due in 2023; and • 798 were due in 2024. Some were marked maintenance in progress, but the vast majority did not indicate maintenance had occurred. This was also evidenced during our sample testing of two assets.	Corporate Governance - Internal Audit/2025/1046/MD3/1	An SBAR was submitted in 2023 with a plan to increase the headcount in CE to resolve the backlog of maintenance created during the pandemic. Planned maintenance is prioritised according to risk, and a plan to mitigate risks will be drafted should recruitment not succeed. The workforce challenges in Clinical Engineering have been acknowledged at EDAHPHCS and work is continuing with HEIW and professional groups to consider options to the improve recruitment pipelines.	Clinical Diagnostics & Therapeutics	01/01/2027	Red	In progress	03/02/2026			
Core Financial Systems (Asset Register Management) April 2024	Director of Finance	04/04/2024	An asset register identification label should be attached to each asset unless there is an operational constraint which prevents it. Where this arises, the reason for the exception should be recorded and approved.	Corporate Governance - Internal Audit/2024/744/MD1/1	Agree with recommendation, exercise to revise labelling to be carried out in 24/25.	Finance	31/01/2027	Green	In progress	20/05/2024		Currently having difficulties identifying appropriate software / suppliers.	Unable to source either software to create labels or preprinted labels in 2024/25 despite contacting several suppliers – this is being prioritised in 2025/26 & the in house systems team is looking at this to allow us to complete a labelling exercise this financial year. Update 26/27 - we have created a program to allow labels to be printed in house. Started sending out labels to directorates in 25/26, this is an ongoing process.
LIMITED - Neurodevelopment Services for Adults	Chief Operating Officer	01/05/2026	Referral Documentation - Referrals for ADHD appointments are often not received in a standard format or are missing vital information which either makes the screening process harder or requires further information to be sought, which lengthens the referral process and takes up valuable staff time. Children's services also used to suffer from this problem, but the introduction of a standard questionnaire has helped to ensure that correct and complete information is received at the first attempt.	Corporate Governance - Internal Audit/2026/1081/MD2/1	The use of a standard questionnaire to be completed by GPs, patients and their families, and other referrers will be considered.	Mental Health	31/01/2027	Amber	In progress	19/05/2026			
LIMITED - Neurodevelopment Services for Adults	Chief Operating Officer	01/05/2026	Shared Care Responsibility - Mentally ill patients whose condition is stabilised through treatment and medication are often accepted back by their GP for ongoing follow-up. However, in the majority of ADHD cases, this shared care responsibility is not being accepted by the GPs, despite the needs of a typical ADHD patient being far less complex than other patients that they do accept shared care responsibility for.	Corporate Governance - Internal Audit/2026/1081/MD4/1	The Health Board will pursue this issue with Primary Care to seek a more equitable sharing of responsibility.	Mental Health	31/01/2027	Red	In progress	19/05/2026			

Cancer Services	Chief Operating Officer	01/05/2024	Risk management and risk reporting approach for the Cancer Services Team be agreed and as a minimum consider the arrangements for: • Identifying the risk; • Analysing the risk; • Prioritising the risk; • Treating the risk; and • Monitoring / escalating the risk as appropriate	Corporate Governance - Internal Audit/2024/748/MD4/1	The Lead Cancer Nurse will create a unified risk register for cancer which will be governed via the Executive Cancer Board. This will be compiled in accordance with the Clinical Boards identifying, risk reviewing and unifying all relevant risks from within their individual risk registers, as well as risks identified internally from within Cancer Services. Those risks identified as most vulnerable will be reviewed at Cancer Executive Board with an expectation that remedial actions be identified and implemented at the point of presentation.	Cancer Services	28/02/2027	Amber	Partially complete	20/05/2024			August 2026 - action extended by 6 months, as it is contingent on an Executive Cancer Board being back up and running, which has not happened yet. July 2024 IA tracker update: Priorities 1. Clinical Board triumvirate contact to inform of Cancer Services risk register and request sharing of the risks held relating to cancer. In accordance with Clinical Boards, populate risk assessments on the Cancer Services risk register by end July 2024 2. Scope risk assessment training needs within Cancer Services and arrange training June 2024 3. Gather risk assessments to populate Cancer Services risk register end July 2024 4. Share with Cancer Services senior leadership team August 2024 5. Present at Executive Cancer Board September 2024
Follow-up: Decarbonisation	Executive Director of Finance	27/04/2026	5.1 - To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not.	Corporate Governance - Internal Audit/2026/1016/MD1/1	The SDP states 'NHS Wales organisations will create or review and update their Climate Action Plans in line with this SDP and ensure clear accountability for delivery of initiatives within their organisations'. As part of the development of the CAP, Management will ensure that, where possible, identified initiatives are supported by indicative costings and financial impact assessments, with input from Finance.	Finance	31/03/2027	Amber	In progress	19/05/2026			
Follow-up: Decarbonisation	Executive Director of Finance	27/04/2026	5.2 - The amount of potential CO2e saving per action should be recorded and linked to the potential cost as per action. This could inform and support the prioritisation of delivery of the action.	Corporate Governance - Internal Audit/2026/1016/MD2/1	The Health Board will consider assessing and recording the potential CO2e savings following the completion of agreed action 5.1.	Finance	31/03/2027	Amber	In progress	19/05/2026			
LIMITED - Follow-Ups Not Booked	Chief Operating Officer	14/08/2026	Inaccurate and Misleading Follow-Up Dataset - Analysis of the Health Board wide FUNB dataset as at March 2026 identified significant weaknesses in the completeness and reliability of follow-up data. The Health Board reported a total of 92,555 follow-up pathways, of which 2,107 pathways had no target date assigned. Consequently, these patients cannot be assessed for timeliness or included in performance monitoring. In addition, 43,027 patients were recorded as overdue, indicating a substantial level of delay across pathways. However, we reviewed 19 pathways, and it confirmed that a large proportion of these pathways are not clinically valid, with patients already discharged or treated remaining on the system. As a result, the dataset is both inflated and incomplete, limiting assurance that follow-up demand and associated risks are accurately understood.	Corporate Governance - Internal Audit/2026/1121/MD4/1	A structured programme will be undertaken to improve the accuracy and completeness of follow-up (FUNB) data. This will include a comprehensive review of existing pathways to remove patients who no longer require follow-up and correct misclassified records. Directorates will be required to assign clinically appropriate target dates to all follow-up patients and ensure pathways are updated or closed in a timely manner. This will be supported by routine validation processes and clear accountability for data quality. In addition, reporting will be enhanced to reflect the full, validated follow-up cohort, ensuring that decision-making and oversight are based on accurate and complete information.	TRUSTWIDE	31/03/2027	Red	In progress	01/09/2026			

Speaking Up Safely	Director of Corporate Governance	23/07/2026	Speaking Up Safely Connector representation across the Health Board - Our review of Connector representation across the Health Board identified that there are currently no Connectors in place within the Surgery Clinical Board, Digital Health & Intelligence and Capital, Estates and Facilities and Finance Directorates respectively. It is unclear why staff within any of these five areas have not expressed interest or volunteered for the Connector role, particularly given their respective staffing levels and breadth of services that cover the Health Board. The absence of Connectors within these areas may lead to the reluctance and inhibition of staff who wish to raise a concern with confidence and be listened to and offered advice in a confidential and psychologically safe manner.	Corporate Governance - Internal Audit/2026/1195/MD4/1	Corporate Governance Department will undertake formal liaison with the respective senior management contacts within the Surgery Clinical Board; Capital, Estates and Facilities; Digital Health & Intelligence and Finance Directorates to further promote the need for and importance of Connectors within their respective areas.	Corporate Governance	31/03/2027	Amber	In progress	01/09/2026			
Risk Management and Board Assurance Framework	Director of Corporate Governance	20/04/2026	Corporate Risk Register - The Corporate Risk Register is reported to every meeting of the Board and contains all operational risks scoring 20 and above. However, the size of the register (186 risks as at March 2026) makes it unrealistic for Board members to scrutinise it in any meaningful way. The Corporate Risk Register is always scheduled at the end of the Board meeting and is provided for noting. The minutes of Board meetings only ever record that it was noted and there is never any record of a discussion of any of the risks contained within it.	Corporate Governance - Internal Audit/2026/1104/MD4/1	It is anticipated that the planned data cleansing of operational risks by the autumn and the subsequent moderation by the SLT will significantly reduce the number of risks included in the Corporate Risk Register (see key finding 2). Over the coming months the Corporate Governance Team will also continue to review current processes to identify how the Corporate Risk Register can be presented to the Board in the most meaningful and effective way.	Corporate Governance	31/03/2027	Red	In progress	19/05/2026			July 2026 - The receipt of the CRR at Board remains under review and is currently being considered in line with targeted intervention requirements. The CRR will be streamlined to highlight key risk themes which aligns to the presentation of risk information to Welsh Government via escalation board meetings. This action will be updated accordingly as this work progresses.
Digital Literacy (Advisory)	Executive Director of People and Culture / Director of Digital and Health Intelligence	05/03/2026	Training Expectations and Pathways - The outcomes of the digital literacy assessment should clearly set out the digital training and development expectations for each role, highlighting the benefits for staff and how the required training will support their progression in digital skills and overall digital literacy. The assessment should also indicate the learning pathways available, helping staff understand how they can continue to develop their skills over time. For staff who already possess advanced digital skills, additional development opportunities should be made available to ensure their capability is recognised, supported, and further enhanced.	Corporate Governance - Internal Audit/2026/1162/MD9/1	1. Undertake role specific training needs analysis in-line with outcome of digital literacy and capability assessment. 2. Review existing training and complete gap analysis and resource required to deliver additional needs. 3. Work with key stakeholders to align with programmes of work around leadership and management, organisational development and culture and talent, succession and career development. 4. Scope out advanced digital qualifications available via local providers which are funded via the Apprenticeship Framework for Wales. 5. Use the DLA to better understand digital exclusion/inclusion amongst our staff groups and use this to drive accessibility and usability of tools	Digital and Health Intelligence	31/03/2027	Green	In progress	19/05/2026			
Reducing Health Inequalities - UNSATISFACTORY	Executive Director of Public Health	17/08/2026	No comprehensive register of systems capturing ethnicity data - The Health Board does not maintain a comprehensive, central register of systems that capture patient ethnicity data. Although certain corporate systems (e.g. PAS, PMS, PARIS, Clinical Portal) are known, there are hundreds of locally managed clinical applications within Clinical Boards, many of which are not inventoried and may collect ethnicity information inconsistently.	Corporate Governance - Internal Audit/2026/1091/MD1/1	Management will develop a system register covering all known corporate systems that capture ethnicity and protected characteristics data.	Public Health	30/04/2027	Red	In progress	01/09/2026			

Reducing Health Inequalities - UNSATISFACTORY	Executive Director of Public Health	17/08/2026	No quality assurance framework for ethnicity data - There is no formal quality assurance framework in place for assessing the completeness or accuracy of the patient ethnicity data that has been collected or checking the integrity of the data as it is collated. There are no baseline completeness thresholds, validation controls, or routine checks in place for monitoring data quality. While strategic frameworks such as the Equity, Equality, Experience and Patient Safety Framework exist, operational accountability for ethnicity data is fragmented across Clinical Boards and corporate teams, with Information Asset Owner (IAO) roles largely unfilled in practice. As a result, there is no clear ownership of data standards, completeness, or improvement actions.	Corporate Governance - Internal Audit/2026/1091/MD3/1	Lead staff in each Clinical Board will be identified to boost completeness of data on protected characteristics, to undertake quality assurance checks and implement routine completeness and exception reporting to ensure data is complete and accurate. Ensure Information Asset Owner roles for systems capturing patient ethnicity are fully assigned and embedded within the Clinical Boards.	Public Health	30/04/2027	Red	In progress	01/09/2026			
Leadership and Management Training / Development	Executive Director of People and Culture	28/05/2026	Development of the Leadership and Management Framework including Clinical Board Engagement / Contribution - There is evidence of ongoing engagement across the clinical boards in relation to the development of leadership and management offerings to enable the framework development. However, no bespoke framework engagement has been undertaken with Clinical Boards in relation to their input into the Leadership and Management Framework, as a decision was made not to do so until the HEIW Leadership and Management Competency Framework is received. However, we note that Leadership and Management Team members met with Clinical Board General Managers in October 2024 to discuss a future General Manager Development Programme for inclusion into the Framework, and there has been extensive engagement to support development of the Clinical Managers' programmes and this is evidenced in the audit file. As a result, there is an opportunity to engage with Clinical Boards to identify their	Corporate Governance - Internal Audit/2026/1120/MD1/1	The draft Framework will be finalised and published as soon as possible once the HEIW Leadership and Management Competency Framework is received. Leadership and Management Programme Leads will continue to engage with Clinical Board and corporate function senior management teams to scope training requirements, helping to further prepare the Framework for completion.	People & Culture	29/05/2027	Amber	In progress	01/09/2026			
Space Utilisation - ADVISORY		10/08/2026	Estates Strategy - The UHB have recently completed a comprehensive condition survey of its estate which along with the development of the clinical services plan will inform a revised estate strategy. The UHB have an accommodation working group which meets to discuss the allocation of space. In addition, an estate rationalisation programme is being progressed with several buildings vacated some community buildings for sale, whilst others on the UHW site being demolished. In undertaking the estate rationalisation programme more efficient use is being made with the existing estate. An exercise to improve and maximise the space, particularly in admin areas is being undertaken to identify further opportunities to vacate poor quality facilities.	Corporate Governance - Internal Audit/2026/1257/MD1/1	The projects are ongoing and full completion is likely to take several years, however it is anticipated that a first draft of the estate strategy will be available in quarter 1 2027/28 subject to the progress with the Clinical Output specification and the direction of travel agreed with WG in relation to the redevelopment of the UHW site.	Capital Estates and Facilities	30/06/2027	Green	In progress	01/09/2026			