

Head of Internal Audit Opinion & Annual Report 2025/26

Cardiff and Vale University Health Board



Reasonable Assurance

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1. Executive Summary


1.1 Purpose of this Report

Cardiff and Vale University Health Board (the 'Health Board') Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Global Internal Audit Standards (GIAS).

1.2 Head of Internal Audit Opinion 2025/26

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2025/26 is:

Reasonable assurance		<p>The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.</p> <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>
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1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the GIAS.

The Internal Audit Plan for 2025/26 year, was presented to the Committee in May 2025. Changes to the plan have been made during the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, and the NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we 'Fully Conform', and our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the

requirements of the GIAS for 2025/26. We can therefore state that our service 'conforms to the IIA's professional standards and to GIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited or Unsatisfactory Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2025/26

Substantial Assurance	<ul style="list-style-type: none"> • GMS Unified Contract Assurance Framework • Occupational Health
Reasonable Assurance	<ul style="list-style-type: none"> • Medicine CB Acute Medicine Model (From 24/25 Plan) • Integrated Annual Plan • Deprivation of Liberties Safeguards • Additional Learning Needs Legislation • Medical Equipment & Devices • Financial Sustainability – Temporary Staffing Controls • C&W CB Governance and Financial Arrangements • Standards of Business Conduct • Risk Management and Board Assurance Framework • Neurodevelopment Services for Children • Rhydlafer Development • Wellbeing Hub Park View • 5 Steps to Safer Surgery • Nurse Staffing Levels • Leadership and Management Training/Development • Local / Shadow IT Systems (Draft) • Medicines Management (Draft)

Limited Assurance	<ul style="list-style-type: none"> • Cyber Security • Clinical Board Adherence to the Managing Attendance at Work Policy • Staff Overpayments • Neurodevelopment Services for Adults • Flexible Working Arrangements for Compressed and Variable Hours (Draft)
Unsatisfactory	<ul style="list-style-type: none"> • Reducing Health Inequalities (Draft)
Advisory/Non-Opinion	<ul style="list-style-type: none"> • Quality & Safety Governance • Implementation of Health Roster Follow-up • Digital Literacy • Medical Staff Deployment • Decarbonisation Follow-up • Alcohol Standards Follow-up • Space Utilisation (Draft)

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work.

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the GIAS, the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic

and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Cardiff and Vale University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2025/26 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of GIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4).

2.4 Head of Internal Audit Opinion

Scope of opinion

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Committee, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management, and control is set out below.

Reasonable assurance		<p>The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.</p> <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>
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This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to any Unsatisfactory and Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there was one unsatisfactory and five Limited audits in 2025/26) as well as addressing implementation of recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2025/26, and reported to the Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.

- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.

Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).

- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and Inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified the majority of reviews carried out during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, two were allocated Substantial Assurance, seventeen were allocated Reasonable Assurance, five were allocated Limited Assurance and one was allocated an Unsatisfactory assurance opinion. Seven reports were also issued where an assurance rating wasn't applicable.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where unsatisfactory and limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Committee for consideration and approval.

Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we had previously used to structure our strategic and one-year operational plans.

<p>Corporate Governance, Risk Management and Regulatory Compliance</p>

We have undertaken three reviews in this area:

- **Standards of Business Conduct:** The Health Board has an appropriate and up-to-date Standards of Behaviour Framework in place, supported by formal policies and procedures for declarations of interests, gifts, hospitality and sponsorship. These arrangements are accessible to staff, aligned with Welsh Government citizen centred governance principles, and are supported by electronic registers and reporting to the Audit and Assurance Committee, providing transparency and a sound control framework. However, while processes exist, declaration rates across the organisation remain low. Inconsistent and limited communication has reduced awareness of ongoing obligations to declare interests and gifts. We concluded **Reasonable** assurance on this area:

- **Risk Management and Board Assurance Framework:** Significant progress has been made during 2025/26 towards the ongoing development and operation of the Health Board's Risk Management arrangements and Board Assurance Framework, particularly with the migration of risks onto the Audit Management and Tracking (AMaT) system. The Board Assurance Framework is clearly linked to the Health Board's strategic objectives and is reported regularly to the Board, with Independent Members recognising improvements in clarity and usefulness compared with the prior year. Areas requiring further management attention included the need to correct and update elements of the Risk Management Policy and supporting documentation, complete data cleansing and moderation of risks within AMaT, and strengthen consistency in how risks are reviewed and escalated through Clinical Boards, Executive reviews and Board sub-committees. We concluded **Reasonable** assurance on this area.
- **Nurse Staffing Levels Act:** Nurse staffing levels on adult acute medical and surgical, and paediatric inpatient wards are calculated using the prescribed triangulated methodology, supported by professional judgement, patient acuity and quality indicators. The Health Board has established clear escalation arrangements and makes appropriate statutory reports to the Board and Welsh Government, providing assurance over external and Board level reporting. We did however identify instances of incomplete or unsigned establishment documentation, variable compliance with SafeCare census completion thresholds, inconsistent updating and closure of red flag staffing issues, and weaknesses in how nurse staffing information is displayed to patients. We concluded **Reasonable** assurance on this area.

A review of the Annual Governance Statement highlighted that it was generally consistent with our knowledge of the Health Board through the audit work performed in the Internal Audit plan and a review of other organisational documents.

Strategic Planning, Performance Management & Reporting

We have undertaken one review in this area:

- **Integrated Annual Plan:** We noted that robust governance and engagement arrangements were in place, with the Health Board's 2025/26 Integrated plan developed through structured involvement of Clinical Boards, Corporate teams, the Senior Leadership Team and the Board, and submitted to Welsh Government in line with required timescales. Strong alignment was also confirmed between the Annual Plan, ministerial priorities and the Health Board's long-term strategy, Shaping Our Future Wellbeing, with clear and measurable objectives and evidence that lessons learned from prior years were being actively used to improve the planning process. Key issues requiring management attention included the scale of the Health Board's underlying financial deficit, the late identification of savings plans to meet the required savings target, and weaknesses in data quality within the Minimum Data Set used to support planning submissions. We concluded **Reasonable** assurance on this area:

The planned audit of Performance Management was deferred from the 25/26 plan due to planned changes in the Clinical Board performance reporting ahead of the organisational re-design.

Financial Governance and Management

We have undertaken two reviews in this area:

- **Financial Sustainability – Temporary Staffing Controls:** The Health Board has established a generally sound control environment, supported by clear workforce strategies, policy frameworks and multi-layered governance arrangements. Controls over nursing and non-medical staffing are relatively mature, underpinned by HealthRoster and well embedded scrutiny through established forums, contributing to improved visibility and control over temporary staffing spend in these areas. Regular and timely reporting provides an effective basis for oversight and challenge. However, significant weaknesses remain within medical and dental workforce planning and governance, which continue to undermine efforts to reduce reliance on temporary staffing and contain costs. The introduction of temporary financial controls in 2025, including a Programme Management Office, improved procedural rigour but did not demonstrate a clear or sustained impact on reducing medical temporary staffing costs. We concluded **Reasonable** assurance on this area.
- **Staff Overpayments:** Staff overpayments remain a material and recurring issue for the Health Board, with overpayments totalling approximately £0.9m between April and December 2025. While an All-Wales Procedure for the Recovery of Overpayments is in place and dashboards are available to support monitoring, weaknesses were identified in awareness, training and consistent application of controls, particularly at line manager and Clinical Board level. Overpayments were largely attributable to late or inaccurate notifications of leavers, changes to hours, absences and payroll adjustments, affecting both medical and non-medical staff groups. Significant control weaknesses were identified in relation to manager awareness of the All-Wales Procedure, the adequacy of induction and training arrangements, inconsistent understanding and use of payroll-related systems (SMA, MSS and HealthRoster), and variable oversight and escalation arrangements across Clinical Boards. Governance and monitoring arrangements were not embedded consistently, with limited evidence of routine scrutiny of overpayments as part of Clinical Board performance oversight. We concluded **Limited** assurance on this area.

The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The audit of Payroll received substantial assurance with Accounts Payable receiving Reasonable Assurance. The audit of PCS Ophthalmology Services received substantial assurance.

Quality & Safety

We have undertaken eight reviews in this area.

- **Deprivation of Liberties Safeguards:** Effective operational processes are in place to manage DoLS applications, supported by a well-maintained database that provides accurate, timely and comprehensive management information. Data on activity levels, application status and assessment outcomes is used to support routine performance discussions with the Local Authority and is reported to relevant Health Board committees. However, governance and compliance gaps identified included the absence of a formally approved DoLS policy and a comprehensive Standard Operating Procedure, and the fact that DoLS training is not currently mandatory for staff, resulting in variable awareness and confidence at ward level. In addition, the volume of DoLS

assessments required routinely exceeds the level of commissioned assessment capacity, contributing to breaches of statutory timescales and potential legal risk. We concluded **Reasonable** assurance on this area:

- **Additional Leaning Needs Legislation:** Appropriate operational systems are in place to manage ALN correspondence and statutory requests, supported by the PARIS system, and complaints, disputes and tribunal arrangements are operating effectively. Governance structures, including the role of the Designated Education Clinical Lead Officer, are established and functioning. However, we identified weaknesses including the absence of an overarching ALN governance policy and strategic implementation plan, inconsistent quality assurance and statutory duty monitoring across services, low and variable attendance at key regional and internal ALN groups, unclear expectations of ALN Champion roles, and gaps in training records and demand planning for future ALN pressures. We concluded **Reasonable** assurance on this area.
- **Medical Equipment & Devices:** While controls around cleaning, decontamination, storage, risk assessment and staff training are generally robust and provide assurance over patient safety in operational areas, there are weaknesses in governance and asset management. Key issues requiring management attention included a significantly overdue policy and procedure, inaccurate and incomplete recording of medical equipment on the Medusa system, particularly within Radiology, substantial backlogs in planned maintenance, and limited Clinical Engineering oversight of Radiology and HSDU/SSU. We concluded **Reasonable** assurance on this area.
- **Quality & Safety Governance:** We undertook an **advisory** review of the effectiveness of the Health Board's quality and safety governance arrangements, following significant concerns identified through an internal review of theatres at University Hospital of Wales and subsequent engagement with Health Inspectorate Wales. Overall, we noted that established governance structures are in place and broadly aligned with Welsh Government expectations, with multiple tiers of quality and safety groups operating across the organisation. Engagement with governance processes is generally good, and there is evidence of committed leadership, professional expertise and regular quality and safety activity at Clinical Board, directorate and specialty levels. However, we identified weaknesses that limit the effectiveness and consistency of assurance. These included the absence of up-to-date central documentation and guidance describing the full quality and safety governance framework, inconsistent reporting and escalation routes between groups, variable frequency and coordination of meetings, and a lack of central oversight such as a register of quality and safety groups and designated leads. While staff demonstrated confidence in reporting concerns, there was reduced clarity and confidence around escalation processes and the timeliness of action.
- **5 Steps to Safer Surgery:** The Health Board has made progress since our earlier audits of this area, confirming that core stages of the 5 Steps to Safer Surgery checklist are now routinely undertaken within theatres and that governance, monitoring and reporting arrangements are in place through the Perioperative Care Directorate, a Health Board wide WHO collaborative group, and quarterly quality audits. Staff consistently demonstrated support for the checklist and an understanding of its importance in improving patient safety and team working. However, weaknesses identified included out-of-date perioperative policies and procedures, incomplete and inconsistent documentation within theatre care plans, variable attendance at key stages of the checklist (particularly sign-out and debrief), and the absence of routine debriefing in practice. There was also limited staff awareness and engagement regarding proposed team briefing whiteboards, and no defined timescale for the full digital implementation

of the WHO checklist within the Aqua Theatreman system. We concluded **Reasonable** assurance on this area.

- **Alcohol Standards Follow-up:** We were able to confirm that all the outstanding agreed management actions from the previous Limited assurance Alcohol Standards audit have now been fully implemented, and the key findings from the original report have therefore been addressed.
- **Reducing Health Inequalities (Draft):** Significant weaknesses were identified across governance, data quality and operational processes, which limit the organisation's ability to effectively collect, analyse and use ethnicity data to support its equality objectives. While a strategic framework for equity exists, this has not translated into consistent operational practice, with low levels of recorded ethnicity data completeness and fragmented data collection across multiple systems. Key issues include the absence of a comprehensive register of systems capturing ethnicity data, lack of formal training or guidance for staff, and no established quality assurance framework to ensure data accuracy and completeness. In addition, data is held in siloed systems with no clear ownership or accountability, and there is limited integration, reporting or use of ethnicity data within governance structures. As a result, the Health Board is unable to demonstrate effective oversight or progress in addressing health inequalities, creating risks in relation to regulatory compliance, service quality and reputation. We concluded draft **Unsatisfactory** assurance on this area.
- **Medicines Management (Draft):** A comprehensive Medicines Code and supporting governance framework are in place, alongside the ongoing implementation of an Electronic Prescribing and Medicines Administration (ePMA) system to enhance medication safety and efficiency. Established processes for prescribing, ordering, storage, administration and monitoring of medicines are generally operating effectively, supported by routine audit activity and appropriate incident reporting mechanisms. However, we identified inconsistent completion of mandatory medicines management training, control weaknesses in medicines storage practices identified during ward visits, and inefficiencies associated with the ePMA "tap to order" function leading to duplicate orders. In addition, a small number of medicines-related incidents and risks had not been investigated or closed in a timely manner. We concluded draft **Reasonable** assurance on this area.

The planned audit of the Diabetes Care Process was deferred from the 2025/26 plan due to ongoing introduction of new processes.

The planned follow-up audit of Interventions Not Normally Undertaken was deferred from the 2025/26 plan due to changes in lead manager and lead Executive.

Information Governance & Security

We have undertaken three reviews in this area.

- **Cyber Security:** While cyber security risks are recognised at a corporate level and there has been tangible progress in strengthening technical controls, we identified significant weaknesses in governance, risk management and communication. In particular, the cyber risk register was incomplete and inconsistently applied, with limited evidence of scrutiny or challenge, and inconsistent application of the organisation's risk appetite. We highlighted inconsistent awareness of cyber risks and an absence of local cyber risks recorded on Clinical Board risk registers. Although a

Cyber Improvement Plan is in place, its coverage does not yet reflect the full organisational risk profile. We concluded **Limited** assurance on this area.

- **Digital Literacy:** Our **advisory** review found that, while the importance of digital literacy is clearly recognised across multiple strategic documents, there is currently no consistent, coordinated or role-specific approach to assessing digital capability across the workforce. Attempts to implement an organisation wide assessment using the national Digital Capability Framework have achieved very low engagement, limiting the ability to understand baseline capability or target training effectively. In the absence of a central approach, a range of localised assessments and training initiatives have emerged, demonstrating commitment and innovation but resulting in fragmented effort, duplication and an incomplete organisational picture. Digital training is available through various channels, and significant investment has supported major system rollouts, but barriers relating to awareness, accessibility, time and limited training capacity continue to constrain uptake.
- **Local / Shadow IT Systems (Draft):** Core digital guidance, procurement controls and strong technical safeguards are in place for locally managed systems, including effective network segmentation, access controls and restrictions on unauthorised software installation. There is constructive working between Digital & Health Intelligence and Procurement, which helps identify most new digital items, and central digital governance is provided through the Digital and Infrastructure Committee. However, much of the existing digital, information governance and security guidance is out of date, and there is no concise, accessible summary of requirements for system owners. Governance gaps remain, particularly the lack of Clinical Board representation at corporate digital forums, which reduces visibility and accountability for devolved digital activity. There is also no complete or accurate inventory of digital systems and suppliers across the organisation. We concluded draft **Reasonable** assurance on this area:

The planned audit of AI – Use of Robotics and Automation was deferred from the 25/26 plan due to overlap with the scope of the Audit Wales Deep Dive into Digital.

Operational Service and Functional Management

We have undertaken five reviews in this area.

- **GMS Unified Contract Assurance Framework:** Our review of the Health Board's arrangements for managing, monitoring and reporting performance against the Framework confirmed that a nationally consistent framework is in place, supported by Welsh Government guidance and training, and that assurance assessments are undertaken using defined national indicators, with outcomes appropriately reviewed through established management and committee reporting arrangements. We concluded **Substantial** assurance on this area:
- **Medicine CB Acute Medicine Model:** The Acute Medicine service has undergone significant redesign in recent years, including the establishment of a dedicated Emergency and Acute Medicine Directorate and strengthened governance and reporting arrangements. Effective oversight mechanisms are in place, with regular performance, quality and risk reporting to the Medicine Clinical Board and onward escalation to Executive Committees and the Board. Systems for monitoring service quality and patient experience were also operating effectively. However, we identified issues relating to staffing and performance management and the retention of medical staffing

records, which limited assurance over whether staffing levels have consistently been sufficient to support timely patient care. Ongoing operational pressures on the Acute Medicine management team, alongside gaps in the documentation, monitoring and reporting of action plans to address performance shortfalls, were also highlighted. We concluded **Reasonable** assurance on this area.

- **C&W CB Governance and Financial Arrangements:** The Clinical Board has appropriate governance frameworks in place, supported by regular performance and financial reporting, effective engagement with Finance Business Partners and established arrangements for monitoring budgetary performance and savings delivery across its three Directorates. Financial management arrangements were assessed as strong, with timely information, regular scrutiny at Directorate and Clinical Board level, and clear links into Health Board level oversight. We did however identify some governance issues, principally relating to the consistency and completeness of governance documentation and meeting arrangements. We concluded **Reasonable** assurance on this area.
- **Neurodevelopment Services for Children:** Our review focused on the processes for triaging referrals, managing waiting lists and assessing performance information. The review was undertaken in the context of unprecedented and sustained growth in demand for ADHD and ASD assessments, with waiting lists increasing significantly in recent years and expected waiting times exceeding three years. Despite severe capacity and system pressures largely outside the Health Board's direct control, the service has established consistent triage arrangements, clear notification processes for families, and a range of pragmatic service redesign initiatives to make best use of available clinical resources. These include revised clinical pathways, mixed clinics, increased use of multi-disciplinary professionals and the introduction of more efficient assessment practices. We did identify significant challenges requiring management attention, primarily relating to capacity, resilience and information systems. These included limited triage resilience, insufficient recurring assessment and administrative capacity, weaknesses in proactive waiting list management, and inadequate management information. We concluded **Reasonable** assurance on this area.
- **Neurodevelopment Services for Adults:** Our review of the Adult service identified significant and systemic weaknesses in the arrangements for adult ADHD services in particular. While the Integrated Autism Service for adults generally operates with clear processes and without significant issues, the absence of a dedicated adult ADHD service has placed unsustainable pressure on Community Mental Health Teams. This has resulted in historically inconsistent triage arrangements, extremely long and growing waiting lists, and inefficient use of highly skilled consultant psychiatrists for activity that could be more appropriately delivered through a specialist nurse led model with clinical oversight. We highlighted several high priority issues requiring management attention, including the unsustainability of the current service model for adult ADHD, limited and fragmented management information, lack of standardised referral documentation, insufficient administrative capacity, refusal by many GP practices to accept shared care arrangements, and poor availability of information for adults and families seeking support. Although progress was made during the audit through the introduction of a new Standard Operating Procedure to improve consistency, we concluded that without significant service redesign and investment, patients joining adult ADHD waiting lists may face waits of many years and, in some cases, may never be seen. We concluded **Limited** assurance on this area.

The planned audit of the CD&T CB Governance Arrangements was removed from the 2025/26 plan and replaced with the audit of Quality & Safety Governance.

The planned audit of the Planned Care Programme was deferred from the 2025/26 plan due to an overlap with the scope of the recent Audit Wales review.

Workforce Management

We have undertaken six reviews in this area.

- **Occupational Health:** The Health Board's current service model, including collaboration with Cwm Taf Morgannwg University Health Board, is operating effectively and provides staff with timely access to Occupational Health support. Referral management, assessment timescales and pre-employment health checks are well controlled, with the majority of Key Performance Indicators met and any delays appropriately justified. Overall, the service is appropriately resourced and delivers effective support to both staff and managers. We concluded **Substantial** assurance on this area.
- **Clinical Board Adherence to the Managing Attendance at Work Policy:** While the All Wales Managing Attendance policy framework is in place, supported by training and comprehensive corporate reporting, there are material weaknesses in the consistent application of key policy requirements at ward and departmental level. Sickness absence monitoring and reporting arrangements are well established, with robust oversight through Clinical Board performance meetings, the People and Culture Committee and the Integrated Performance Report, supporting organisational focus on reducing sickness absence towards the Health Board's target. We identified several high priority issues, including inconsistent and inaccurate sickness absence recording, incomplete retention of supporting documentation, unactioned policy review triggers and delays in undertaking return to work meetings. These weaknesses undermine the effective management of attendance and increase the risk of policy non-compliance, data inaccuracy and avoidable levels of absence. We concluded **Limited** assurance on this area.
- **Implementation of Health Roster Follow-up:** We were able to confirm that two of the four remaining outstanding agreed management actions from the previous Limited assurance audit have now been implemented, and the associated key findings from the original report have therefore been addressed. Whilst some progress has been made, further work is still required to fully implement the two remaining actions relating to the timely processing of rosters and the consistent verification and finalisation of shifts.
- **Medical Staff Deployment:** Our **advisory** review of Medical Staff Deployment assessed the robustness of arrangements for medical job planning, rostering, and the management of annual leave and sickness absence. We identified clear strategic intent and evidence of progress, particularly in improving compliance with consultant and SAS job planning. Strong governance structures are in place, centred on the Medical Workforce Advisory Group (MWAG), supported by executive sponsorship and regular reporting to senior committees. These arrangements demonstrate a clear commitment to strengthening medical workforce deployment and readiness for national initiatives such as the Welsh Resident Doctor Contract and the All-Wales medical e-rostering solution. We did however identify important structural and operational weaknesses that limit the effectiveness of current arrangements. Medical rostering remains fragmented across multiple systems, with significant variation in rota design and compliance. Job

plans are not yet consistently underpinned by demand and capacity modelling or aligned with rota patterns.

- **Leadership and Management Training / Development:** The Health Board has a comprehensive range of clinical and non-clinical leadership and management programmes in place, supported by appropriate resourcing. Strong processes exist to monitor attendance, completion and acquire participant feedback which is actively used to improve course content and delivery. The forthcoming 2026/27 Leadership and Management Framework provides a coherent strategic basis for future development and aligns with national priorities, the Health Board's Annual Plan and core organisational principles. We did identify limited engagement with Clinical Boards in the development of the Leadership and Management Framework, a lack of clarity within the draft framework on the full range of programmes available and the absence of routine reporting of programme performance and outcomes to the People and Culture Committee. We concluded **Reasonable** assurance on this area.
- **Flexible Working Arrangements for Compressed and Variable Hours (Draft):** While an appropriate policy framework is in place, including the All-Wales Flexible Working Policy and supporting guidance, we identified inconsistent awareness and application of these requirements in practice. Formal processes for requesting and approving flexible working arrangements are not consistently followed, with instances of undocumented arrangements and incomplete or inaccurate records on ESR. Significant control weaknesses were also identified in the management of annual leave and bank holidays for staff working non-standard patterns. Testing demonstrated that leave is not always recorded in line with contracted hours, increasing the risk of staff exceeding their entitlement. Weaknesses in governance, data accuracy and recording arrangements further limit the organisation's ability to monitor compliance and ensure equitable application of flexible working arrangements. We concluded draft **Limited** assurance on this area.

Capital & Estates Management

We have undertaken four reviews in this area.

- **Decarbonisation Follow-up:** We were able to confirm that all the agreed management actions from the previous Limited assurance Decarbonisation audit have been fully implemented, and the key findings from the original report have therefore been addressed.
- **Rhydlafar Development:** Appropriate controls and oversight arrangements are in place and operating effectively overall for the development of the new Pentyrch Branch Surgery. At the time of review, the project remained forecast to be delivered within the approved budget, supported by effective cost control and risk management arrangements, although completion was approximately three months behind the original programme with further external risks to timescales identified. A small number of matters were identified, including weaknesses in performance monitoring and reporting arrangements, non-completion of contractor Key Performance Indicators, planning conditions were not being centrally tracked, and inaccuracies were noted within project progress reports submitted to Welsh Government. We concluded **Reasonable** assurance on this area:
- **Wellbeing Hub Park View:** The project has experienced significant time and cost pressures since the Outline Business Case, with the delivery timetable extended by

almost two years and the capital cost increasing substantially, largely driven by external factors. Despite these challenges, we found that core management controls across approvals, financial management, contractual arrangements, planning and design development were generally in place and operating. Several matters were identified including the need to clarify how the “project board” role will be fulfilled, strengthen the timeliness and clarity of reporting on programme slippage and cost escalation, ensure contracts and adviser appointments are consistently executed in line with Standing Orders, and improve the timing and robustness of target cost reporting to support effective scrutiny and approvals. We concluded **Reasonable** assurance on this area.

- **Estates Assurance – Space Utilisation (Draft):** Our **advisory** review identified that arrangements remain at an early stage of maturity, with limited availability of robust utilisation data and an out-of-date Estates Strategy (2018–2028), restricting the ability to monitor performance and drive improvement. Whilst some progress has been made, most notably the ongoing development of a Clinical Services Plan, completion of estate condition surveys, and the ongoing Community Assets Review, headline indicators suggest that strategic objectives for space utilisation have not yet been achieved. Key improvement opportunities include the need to refresh the Estates Strategy with clear, measurable targets; strengthen governance, oversight and accountability arrangements; and develop supporting policies and procedures. In addition, improvements are required in data capture, including greater use of available tools (such as OccupEye) and the development of a centralised data repository, alongside enhanced monitoring and reporting of utilisation performance.

2.5 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit action tracker.

In addition, Audit Committees monitor the progress in implementing agreed actions (this is wider than just Internal Audit actions) through their own action tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees to consider and agree the adequacy of management actions and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of agreed actions, on both our ability to give an overall opinion (in compliance with the GIAS) and the level of overall assurance that we can give.

From the specific follow-up audits of Implementation of Health Roster, Decarbonisation and Alcohol Standards undertaken in 2025/26, it was identified that good progress had been made by management with all but two of the agreed actions fully implemented.

Through 2025/26, the Corporate Governance team has continued to review all outstanding actions with management, and the outcomes have been periodically reported to the Committee.

We undertook work towards the end of the year to validate the stated position for a sample of the actions that had been recorded as complete within the Health Board's tracker during 2025/26. We were able to confirm the recorded position for all of the sampled actions and therefore provide the Committee with additional assurance around the accuracy of the tracker.

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2025/26 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2025/26.

2.9 Statement of Conformance

The Welsh Government determined that the GIAS would apply across the NHS in Wales from 1 April 2025.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with GIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, who concluded we 'Fully Conform' with the Standards.

The NWSSP Audit and Assurance Services can assure the Committee that it has conducted its audit at the Health Board in conformance with the GIAS for 2025/26.

Our conformance statement for 2025/26 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2025/26 which will be reported formally in the Summer of 2026; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the GIAS and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2025/26 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2025/26.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit Committee and Chair of the Health Board.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and

- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Health Board

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation’s audit programme, will cover activities relating to other health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the Purchase to Pay process.
PCS General Ophthalmic Services	Substantial	To evaluate the adequacy of controls in place to administer timely and accurate payments to general ophthalmic services (GOS) contractors
Payroll	Substantial	to evaluate the design and operation of the systems and controls in place within payroll services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Programme Management	Reasonable	To provide assurance over the timely rollout of a sample of digital programmes / projects across Wales and steps taking place to overcome obstacles, challenges and manage the delivery of benefits.
Cyber Security	Reasonable	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.
GMS Clinical System Migration Project	Reasonable	To assess the management and delivery of the GMS Clinical System Migration project.
CaNISC	Reasonable	To ensure the risks associated with the withdrawal / replacement of the Cancer Network Information System Cymru (CaNISC) are appropriately managed.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

NHS Wales Joint Commissioning Committee (JCC)

The work at the JCC is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Outline scope
IPFR	Substantial	This review considered the system in place for the management and consideration of IPFR applications.
Budget Management	Reasonable	This review considered the budget management process within the JCC, including procedures, responsibilities and management arrangements.
High-Cost Drugs	TBC	This review covered the processes and arrangements relating to high-cost drugs commissioned by the JCC.

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit

Opinion and Annual Report, and the JCC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2026/27 operational audit plan.

The audit plan approved by the Committee in May 2025 contained 35 planned reviews. Changes have been made to the plan with 6 audits removed or deferred and 4 added. All these changes have been reported to, and approved by, the Committee.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	March 2025	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2025/26	G	97% 32/33	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 32/32	95%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [15 working days]	A	70% 19/27	85%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 27/27	95%	v>20%	10%<v<20%	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 32 audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

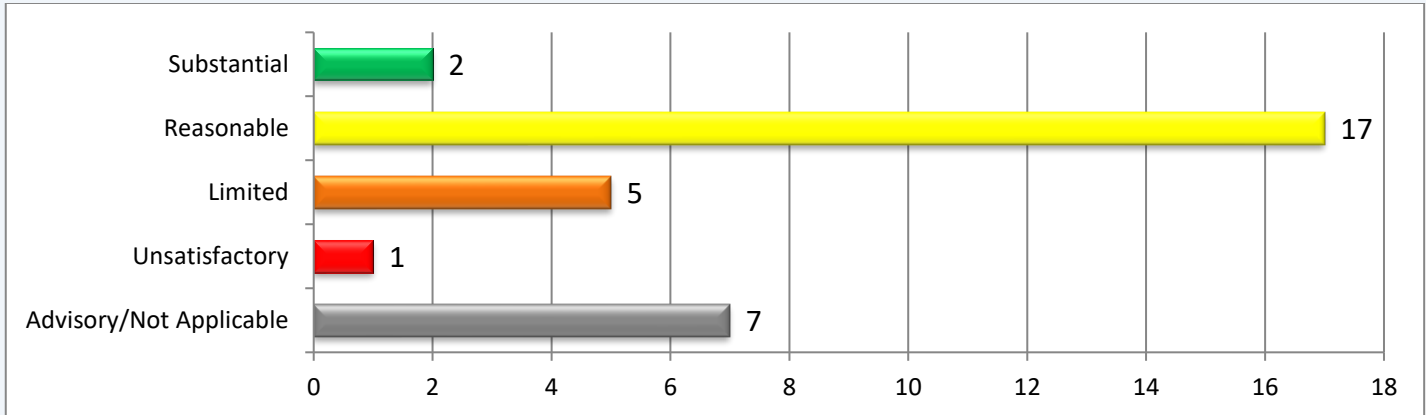


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
GMS Unified Contract Assurance Framework	To review the processes for managing the GMS Unified contract performance framework and monitoring and reporting performance.

Review Title	Objective
Occupational Health	To review the current structure and robustness of the service and processes in place to ensure effective delivery against KPIs and targets.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Medicine CB Acute Medicine Model (From 24/25 Plan)	To review the arrangements in place for development and delivery of the Acute Medicine Model / Same Day Emergency Care.
Integrated Annual Plan	To review the processes undertaken for the development of the 2025/26 IMTP Annual Plan.
Deprivation of Liberties Safeguards	Review of the arrangements for ensuring compliance with DoLS requirements.
Additional Learning Needs Legislation	To provide assurance on the arrangements in place to ensure compliance with the Additional Learning Needs and Education Tribunal (Wales) Act.
Medical Equipment & Devices	To evaluate and determine the adequacy of the systems and controls in place within the Health Board for the management of Medical Equipment and Devices including implants.
Financial Sustainability – Temporary Staffing Controls	To review how the Health Board deploys its workforce to ensure effective and efficient utilisation of the substantive resource, and limitation of the use of temporary staffing, including overtime, bank and agency costs.
C&W CB Governance and Financial Arrangements	To review the structure and Governance arrangements within the Clinical Board including escalation processes and how the Clinical Board feeds into the Health Board’s Committees and Board.
Standards of Business Conduct	To review the adequacy of the systems and controls in place within the Health Board for the management of standards of behaviour. Including declarations of

Review Title	Objective
	interests and declarations of gifts, hospitality and sponsorship.
Risk Management and Board Assurance Framework	To review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.
Neurodevelopment Services for Children	To review the procedures for assessing whether children are added to waiting lists, and the subsequent management of those lists to ensure that those referred are assessed in a timely, fair and consistent manner.
Rhydrafar Development	To evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
Wellbeing Hub at Park View	To evaluate the progression and delivery of the project through to the submission of the FBC and against the key outline business case objectives. Also, to assess the adequacy of the systems and controls in place to support the successful delivery of the project.
Nurse Staffing Levels	Review of processes in place to ensure compliance with the requirements of the Nurse Staffing Levels (Wales) Act.
5 Steps to Safer Surgery	To establish if effective arrangements are in place to ensure all stages of the five steps to safer surgery checklist are consistently undertaken.
Leadership and Management Training / Development	To review the on-going work to develop and deliver leadership and management training within the Health Board.
Local / Shadow IT (Draft)	To review the processes and guidance in place within the Health Board's Digital team for ensuring appropriate professional oversight of locally managed IT systems to ensure they comply with best practice.
Medicines Management (Draft)	To review Medicines Management arrangements following introduction of the electronic system, including a focus on medication safety and management of risks

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Cyber Security	To review how the Health Board is working to improve its cyber security position, and the processes in place for monitoring compliance and providing assurance that the risks are appropriately stated and in line with the risk appetite.
Clinical Board Adherence to the Managing Attendance at Work Policy	To review how the requirements of the Policy are being implemented within the Clinical Boards to ensure that sickness absence is being effectively managed.
Staff Overpayments	Review the processes and controls in place to ensure that staff are correctly paid, and instances of overpayments are limited, and are promptly identified and corrected where they do occur.
Neurodevelopment Services for Adults	To review the procedures for assessing whether adults are added to waiting lists, and the subsequent management of those lists to ensure that those referred are assessed in a timely, fair and consistent manner.
Flexible Working Arrangements for Compressed and Variable Hours (Draft)	To review the process for how flexible working arrangements relating to compressed hours are agreed, reviewed and worked and how annual leave is managed for those working compressed hours.

5.5 Unsatisfactory (Red)



Review Title	Objective
Reducing Health Inequalities (Draft)	To review the processes for collecting ethnicity data within primary and secondary care, and how the data is being utilised to identify and reduce health inequalities.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Quality & Safety Governance	To review the appropriateness and effectiveness of the Quality and Safety Governance arrangements within the Health Board.
Implementation of Health Roster Follow-up	To establish and validate the level of progress that has been made towards the implementation of the agreed management actions from previous Limited assurance audit.
Digital Literacy	To review the plans to assess and improve the level of digital literacy within the Health Board to prepare the organisation for digital transformation.
Medical Staff Deployment	To review the plans in place for medical job planning, rostering, annual leave and sickness management and progression of them.
Decarbonisation Follow-up	To establish and validate the level of progress that has been made towards the implementation of the agreed management actions from previous Limited assurance audit.
Alcohol Standards Follow-up	To establish and validate the level of progress that has been made towards the implementation of the agreed management actions from previous Limited assurance audit.
Estates Assurance – Space Utilisation (Draft)	To determine the adequacy of, and operational compliance with, established systems for the management, control and utilisation of space within the UHB.

5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for removal / deferral
CD&T CB Governance Arrangements	Removed from the 2025/26 plan and replaced with the audit of Quality & Safety Governance.
Diabetes Care Process	Deferred from the 2025/26 plan due to ongoing introduction of new processes.
Performance Management	Deferred due to planned changes in the CB performance reporting ahead of the organisational re-design.
Interventions Not Normally Undertaken Follow-up	Deferred from the 2025/26 plan due to changes in lead manager and lead Executive.
AI – Use of Robotics and Automation	Deferred from the 2025/2026 plan due to overlap with the scope of the Audit Wales Deep Dive into Digital.
Planned Care Programme	Deferred from the 2025/26 plan due to an overlap with the scope of the recent Audit Wales review.

5.8 Work in progress

At the time of producing the Annual Report, the following audit was still in progress and the assurance rating had not been determined. The outcome of this audit will therefore feed into the HIA Opinion for 2026/27.

Review Title	Objective
Follow-ups Not Booked	To review the processes in place to manage patient follow-ups and identify and address patients who have been lost to the follow-up process, in order to minimise the risk of harm.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2025/26 plan.

Ian Virgill

Pennaeth yr Archwiliad Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasaethau GIG Cymru/NHS Wales Shared Services Partnership

June 2026

Appendix A

Internal Audit compliance with the Global Internal Audit Standards and the UK Public Sector Practice Note

Global Internal Audit Standards – Domains, Principles & Standards	Requirements & Response
<p>Domain I: Purpose of Internal Auditing</p>	<p>Internal auditing strengthens the organisation’s ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight.</p> <p>Advice and assurance are provided primarily through a risk-based audit plan approved and monitored by the Audit Committee. Audit & Assurance uses the results of its audits, together with focused research, to provide insight and foresight.</p>
<p>Domain II: Ethics & Professionalism</p> <p>Principles 1 (Demonstrate Integrity), 2 (Maintain Objectivity), 3 (Demonstrate Competency), 4 (Exercise Due Professional Care), and 5 (Maintain Confidentiality). 13 individual standards.</p>	<p>Audit & Assurance has established processes for dealing with both the ethics and professionalism of Internal Audit and the need to maintain client confidentiality. This encompasses training, declarations of interest returns, our audit processes, and the requirements (where appropriate) of professional accounting and audit bodies.</p>
<p>Domain III: Governing the Internal Audit Function</p> <p>Principles 6 (Authorised by the Board), 7 (Positioned Independently), and 8 (Overseen by the Board). 9 individual standards.</p>	<p>How we interact and work with each NHS Wales organisation is set out in the Internal Audit Mandate and Charter which is updated annually. There are appropriate arrangements in place for Internal Audit to act independently and interact with the Board to ensure effective Governance arrangements.</p>
<p>Domain IV: Managing the Internal Audit Function</p> <p>Principles 9 (Plan Strategically), 10 (Manage Resources), 11 (Communicate Effectively), and 12 (Enhance Quality). 16 individual standards.</p>	<p>The Internal Audit function for NHS Wales is managed through the NHS Wales Shared Services Partnership (NWSSP). The Audit & Assurance service delivery plan forms part of the NWSSP integrated medium term plan.</p> <p>A risk based strategic and annual plan is developed for each NHS Wales organisation. The annual plan gives detail of specific assignments and sets out the overall resource requirement. The audit</p>

	<p>strategy and annual plan is approved by the Audit Committee.</p> <p>Quality assurance and control arrangements are in place and are subject to an external assessment at least once every five years.</p> <p>Policies and procedures which guide the Internal Audit activity are in place. There is structured liaison with Audit Wales, HIW and Counter Fraud.</p>
<p>Domain V: Performing Internal Audit Services</p> <p>Principles 13 (Plan Engagements Effectively), 14 (Conduct Engagement Work), and 15 (Communicate Engagement Results and Monitor Action Plans). 14 individual standards.</p>	<p>Audit & Assurance has a Quality Manual that sets out how we will conduct and monitor audit engagements and this is then replicated in our Electronic Working Paper system (ESRA) and other files.</p> <p>This ensures that we meet the requirements to plan, conduct and communicate audit engagement appropriately and follow-up management actions.</p>

[Global Internal Audit Standards](#)

[UK Public Sector Application Note](#)

Appendix B

Assurance Opinion

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Cardiff and University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

