Follow Up Review

Final Internal Audit Report

2025/26

Swansea Bay University Health Board

No overall assurance assigned to this work

Contents

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Fieldwork	August 2025 to March 2026
Executive Sign Off	17 June 2026
Audit Committee	16 July 2026
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Executive Summary

Purpose and approach

This review assessed whether internal audit recommendations have been effectively implemented. It also considered the effectiveness of the systems and arrangements in place to monitor progress with the implementation of actions.

As agreed with the Swansea Bay University Health Board (the 'health board'), and previously communicated through our progress reports to the Audit Committee, a revised follow-up approach has been introduced for the 2025/26 Internal Audit plan year. A minimum of 50% of high priority findings and 10% of medium priority findings from internal audit reports issued during 2024/25 were subject to review throughout the year, with updates provided at each Audit Committee meeting. Selection was based on recommendations recorded as closed within the heath board's recommendation tracker.

This follow-up review does not provide assurance against the full scope and objectives of the original audits, nor does it confirm that all underlying issues have been fully resolved. Accordingly, no overall assurance opinion has been assigned to this work.

Overview

The health board's arrangements to track progress against audit findings remain established and generally effective, supported by regular reporting to the Executive Team and Audit Committee. Audit Wales' Structured Assessment 2025 recognised these arrangements; however, as previously reported, further improvement is required to strengthen the consistency, timeliness, and effective implementation of agreed actions.

At the time of review, there has been a recent increase in overdue internal audit actions, driven by a backlog awaiting verification of supporting evidence, combined with capacity pressures and the transition to the Audit Management and Tracking (AMaT) system. This system is already being used to capture and monitor recommendations from other external inspection bodies, supporting the move towards a more integrated, single source of assurance. Approximately 60 actions were subject to evidence review, with management indicating that a significant proportion are expected to be closed once verification is complete. Our testing confirmed that the verification process remains robust, with actions only closed where sufficient and appropriate evidence is provided.

While this represents a point-in-time position rather than a systemic deterioration, it has reduced the timeliness and clarity of reporting. The backlog includes actions associated with higher-risk areas, including those linked to patient safety, reinforcing the importance of timely verification and closure. The position also highlights a dependency on sufficient capacity within the verification process to maintain timely assurance. Management actions are underway to address the backlog and strengthen arrangements, alongside work to enhance the quality of reporting through increased thematic analysis to support improved oversight, accountability and organisational learning.

Follow-up testing results

A total of 148 recommendations were raised in 2024/25, of which 147 were originally due for closure by 31 March 2026. Of these, 86 have been closed, representing a closure rate of 58.5%. Following completion of our testing, a further six recommendations relating to 2024/25 have since been closed on the tracker, and an additional 31 recommendations have been proposed for closure, pending review by the Corporate Governance Department.

A total sample of 22 closed recommendations (14 high priority; 8 medium priority) was selected for validation, including 6 recommendations from the Safety Notices and Alerts (2021/22) and Continuing Healthcare (2022/23) limited assurance reviews, which had previously been reported as 'in progress'.

Progress was reported to each Audit Committee meeting, with conclusions from follow-up reviews reported as follows: recommendations due by 31 March 2025 were reported in November 2025; those due by 31 July 2025 were reported in January 2026; and those due by 30 November 2025, were reported in March 2026. Recommendations due by 31 March 2026 were included in this review; however, as only two additional recommendations had been closed, no further sampling was undertaken as the agreed sample size had already been met.

Our testing confirmed that all 22 recommendations reviewed were appropriately classified as complete on the tracker. However, in a number of cases, initial evidence provided to support closure was insufficient and required further clarification. Additionally, while actions had been formally closed, further work remains in some instances to fully mitigate the associated risks.

At a glance

The table below sets out the total number of recommendations raised across all reports completed under the agreed 2024/25 Internal Audit plan:

As per original Internal Audit Report					As per audit tracker up to 31 March 2026		
Number of internal audit reports		Recommendations raised			Recommendations closed		
		High priority	Medium priority	Total	High priority	Medium priority	Total
Limited Assurance	9	27	32	59	16	21	37
Reasonable Assurance	16	6	83	89	2	47	49
Substantial Assurance	1	0	0	0	0	0	0
Advisory	1	Whilst actions were raised at this report (Contract Management) they were to be taken forward in partnership with other NHS Wales organisations, including NWSSP Procurement Services, and have not been included on the tracker.					
All reports	**27**	**33**	**115**	**148**	**18 (54.5%)**	**68 (59%)**	**86 (58%)**

Our analysis of the health board's quarter four tracker report to Audit Committee highlights that 69.1% of all internal audit recommendations raised since 2022/23 are recorded as closed (All Wales average[1]: 67.3%), 15.9% are not yet due (All Wales average: 19.7%), with the remaining 15% overdue (All Wales average: 12.9%).

The remaining open recommendations relate to 20 internal audit reports, comprising of:

Limited assurance (8 reports):

- Asset Management (1 high, 2 medium)
- Business Continuity Management (2 medium)
- Clinical Coding (1 medium)
- Mortuary Services (4 high, 4 medium)
- Population Health Strategy (2 high, 2 medium)
- Quality Assurance Framework (1 high)
- Records Management (2 high)
- Speaking Up Safely (1 high)

Reasonable assurance (12 reports):

- Acute Medical Services Redesign Programme (6 medium)
- Child and Adolescent Mental Health Service Transition (5 medium)
- Data Quality (1 high, 1 medium)
- Discharge Planning (7 medium)
- Estates Condition (3 medium)
- Job evaluation (3 medium)
- Learning from Incidents and Concerns (5 medium)
- Mortality Reviews (1 high)
- Neath Port Talbot PFI (1 high, 1 medium)
- Primary Care Cluster Plans (1 high, 2 medium)
- Risk Management and Assurance (1 medium)
- Service Group Governance Arrangements (2 medium)

[1] The All Wales average is calculated using the most recent data available within the recommendations database maintained by Audit & Assurance. At the time of reporting, some organisations were still in the process of updating their Quarter 4 data.

The table below summarises the sample of closed recommendations (up to 31 March 2026) selected for review from during the year. Full details of testing are provided in the next section: *Progress with prior year recommendations.*

Number of reports included in sample		High priority findings sampled	Medium priority findings sampled	Total findings sampled
Limited Assurance Reports	6	8	-	8
Reasonable Assurance Reports	7	1	7	8
	13	**9** [1]	**7** [2]	**16**

A further 5 high priority and 1 medium priority findings from 2 limited assurance reports (Safety Notices and Alerts 2021/22 and Continuing Healthcare 2022/23 were selected for review, which had previously been reported as 'in progress' in earlier follow-up reviews.

[1] *As per the audit tracker (see Table 1), 18 high priority recommendations had been closed by 31 March 2026; this sample meets the 50% requirement set out in our follow-up approach.*

[2] *As per the audit tracker (see Table 1), 68 medium priority recommendations had been closed; this sample meets the 10% requirement.*

Corporate approach to tracking recommendations

The audit tracker is maintained by the Corporate Governance Team, which receives all internal and external audit reports to ensure that all recommendations are captured for reporting to the Audit Committee. All final internal and external audit reports continue to be made available on the Finance Portal on SharePoint, enabling managers and Executive Directors to access and update actions through the audit tracker. Supporting arrangements remain in place, including training and user guidance, to promote consistent use. The Corporate Governance Team continues to prepare regular summary reports of overdue actions, which are reported to the Executive Team, alongside forward-looking information on actions due.

Reporting deadlines for Audit Committee are clearly defined, and the Committee continues to review the status of recommendations and refer audit reports to relevant Board Committees for oversight and scrutiny in line with their remit. In addition, the health board has maintained its practice of requiring Executive Directors to attend Audit Committee to provide assurance on 'Limited' Assurance reports, supporting enhanced scrutiny and accountability. The Audit Committee maintains overall oversight of the implementation of agreed actions, escalating issues to the Board where necessary, and reinforcing accountability by requiring responsible Directors to attend where actions are overdue.

Audit Wales' Structured Assessment 2025 (issued December 2025) recognised that the health board has established arrangements for tracking audit recommendations, supported by an audit tracker subject to Executive-level review and reported to each Audit Committee. While these arrangements remain in place, the current position indicates ongoing challenges in translating this framework into timely implementation and closure of actions. As such, there remains a need to strengthen the health board's approach to the effective implementation of actions, including consideration of how progress against recommendations is embedded within performance management arrangements to support improved accountability and oversight.

As reported to the May 2026 Audit Committee, there has been a recent increase in overdue internal audit actions. This position is, in part, attributable to a backlog of recommendations awaiting verification of supporting evidence prior to closure, together with capacity pressures and a period of system transition from spreadsheet-based tracking to the AMaT system (which is already being used to capture and monitor recommendations from other external inspection bodies e.g. Healthcare Inspectorate Wales). At the time of reporting, approximately 60 actions were subject to evidence review, with management indicating that a significant proportion are expected to be closed once verification is complete. The verification process itself remains robust, with actions only closed where sufficient and appropriate evidence is provided, as confirmed through our sample testing.

While this represents a point-in-time position rather than a sustained deterioration, the backlog has reduced the timeliness and clarity of reporting and the reported position on overdue actions should therefore be interpreted with a degree of caution until verification activity is completed. The backlog includes actions associated with higher-risk areas, including those linked to patient safety, reinforcing the importance of timely verification and closure. The position also highlights a reliance on sufficient capacity within the verification process to maintain timely assurance.

In parallel, the health board is progressing work to strengthen analysis and reporting within audit tracker updates, including the development of more thematic insight (e.g. lessons learned, recurring issues and areas where timeliness of implementation has been challenging). This is intended to enhance the quality of information reported to the Audit Committee and support improved oversight, accountability and learning from audit activity. Management actions to address the backlog are ongoing, and it is expected that this will result in a more accurate and reliable position being reported in subsequent updates.

Results of Follow-Up Testing on Sampled Recommendations

Safety Notices and Alerts (2021/22): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2.1	**Strengthening of Monitoring, Compliance and Escalation Arrangements for Safety Alerts** We recommend that formal deadlines are set for completing actions arising from safety notices and alerts. These deadlines should align with specified requirements, or, where none exist, be formally set by the relevant Level 0 Responsible Person. We also recommend that compliance with actions is proactively monitored, evidenced, and supported by a clear audit trail.	Director of Corporate Governance October 2022	**High**	Deadlines for safety alerts are now set and recorded within the system, with clear expectations for prompt cascade to service groups. A formal procedure outlines requirements for monitoring, reporting and maintaining an audit trail. These arrangements are supported by active governance oversight and escalation processes, providing assurance that compliance is tracked, evidenced and appropriately managed. **Conclusion**: Action implemented as agreed.
4.1	**Improved Governance and Oversight of Safety Notices and Alerts** A more robust monitoring and reporting process should be implemented, including the development and use of KPIs for each alert type, particularly to monitor compliance. A formal escalation route should also be established and documented.	Director of Corporate Governance October 2022	**Medium**	Monitoring and reporting arrangements have been strengthened through updated procedures and the introduction of operational KPIs to track compliance. A formal escalation process has been defined and embedded within policy, providing clear routes for managing non-compliance, delays and associated risks. These are evidenced through active monitoring and governance oversight. **Conclusion**: Action implemented as agreed.

Continuing Healthcare (2022/23): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
Strengthened Strategic Oversight and Operational Consistency in Continuing Healthcare (CHC)				
2.1	The health board should review its current structure to ensure appropriate arrangements are in place for strategic oversight for CHC.	Interim Director of Strategy November 2023	**High**	The health board has approved plans to transition to a centralised CHC commissioning model to strengthen strategic oversight and improve consistency. This includes establishment of a central team, defined roles and reporting structures, and enhanced governance arrangements. Implementation is underway, with progress monitored through Management Board and committee reporting. **Conclusion**: Action implemented as agreed.
2.2	The health board should review processes at service group level to identify opportunities to improve efficiency and streamline processes, while remaining compliant with the National Framework.	Service Group Director (PCTG) / Service Group Director (MH&LD) January 2023	**High**	The health board has worked with the National Collaborative Commissioning Unit (NCCU) to develop a centralised CHC commissioning model supported by a standard operating procedure (SOP), promoting consistency and improved efficiency. The SOP has been approved and communicated through governance structures. Further refinement is planned through ongoing work to standardise practices across service groups. **Conclusion**: Action implemented as agreed.
2.3	Service groups should collaborate to better understand and address system-wide CHC challenges.	Service Group Director (PCTG) / Service Group Director (MH&LD) November 2023	**High**	Collaboration has been strengthened through NCCU-supported workstreams and the establishment of a central CHC Programme Board. Joint initiatives, including a shared SOP, performance dashboards, and coordinated improvement projects, demonstrate improved cross-service working and a more consistent approach to CHC processes. **Conclusion**: Action implemented as agreed.

Improved Governance, Collaboration and Monitoring Arrangements for CHC				
7.1	Service groups should implement routine monitoring of CHC reviews to ensure completion within required timescales.	Service Group Director (PCTG) / Service Group Director (MH&LD) October 2023	**High**	Routine monitoring has been strengthened, with structured datasets now used to track review dates, case ownership, and compliance. Monthly reporting and increased workforce capacity have improved oversight and planning, supporting timely completion of statutory reviews. **Conclusion**: Action implemented as agreed.

Asset Management (2024/25): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
4	**Physical Verification of Assets** 2023/24 was the first year physical verification resumed following the Covid-19 pandemic. Due to capacity constraints, the exercise was not completed within the preferred timeframe (during the course of the summer months). At the point of completion, a significant proportion of sampled assets could not be located. No evidence was available to demonstrate that discrepancies were investigated or reported in line with Financial Control Procedures (FCP).	Assistant Director of Finance June 2025	**High**	Outstanding assets from the 2023/24 exercise have been incorporated into the 2024/25 verification process. Reconciliations have been completed and formally signed off by the Director of Finance. Verification records now include previously unaccounted-for assets, demonstrating improved completeness, follow-up of discrepancies, and strengthened assurance over the asset verification process. **Conclusion:** Action implemented as agreed.

Business Continuity Management (2024/25): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
4	**Accuracy and Completeness of the Dashboards** Our analysis of dashboards and testing of a sample of business continuity plans (BCPs) identified that dashboards were not consistently maintained by service areas. We also noted legacy BCPs stored on a Teams channel that is no longer in active use, although this has since been replaced by dashboard reporting.	Head of EPRR working with Digital Services Head of EPRR Completed post fieldwork	**High**	Dashboards have been standardised, with Emergency Preparedness, Resilience and Response (EPRR) Leads reminded of their responsibility for maintaining accurate and complete entries, reinforced through governance meetings. Phase two development has introduced increased automation to reduce manual error. Legacy BCPs have been archived. Collectively these actions have improved the accuracy, consistency, and reliability of dashboard information across services. **Conclusion**: Action implemented as agreed.
5	**Quality of Business Continuity Plans (BCPs)** Testing of a sample of 10 BCPs identified a number of weaknesses, including: drafts remaining incomplete (including plans dating back to 2019 and 2023); inaccessible plans; missed review dates; incomplete use of the corporate template; lack of formal approval records; limited evidence of reporting within service areas; and insufficient recent testing.	Head of EPRR, working with all EPRR leads December 2025	**High**	Findings were formally shared with EPRR Leads and reinforced through dedicated sessions and Strategy Group meetings. Actions focused on improving BCP completion, approval and review processes, supported by ongoing monitoring of compliance. These actions taken have increased awareness, accountability and consistency, supporting embedding of business continuity management into routine practice. **Conclusion**: Action implemented as agreed.

Clinical Coding (2024/25): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1.1	**Strengthening Workforce Planning and Efficiency in Clinical Coding** A full assessment should be undertaken to evaluate the resources required to meet organisational clinical coding demand, taking into account workload, complexity and regulatory requirements. This should inform an improvement plan to maximise efficiency and utilisation of coding resources.	Assistant Director of Digital Intelligence October 2024	**High**	A resource and improvement plan has been developed, covering a two-year period. This includes workforce planning, recruitment and development of trainee coders, and exploration of automated coding solutions to improve productivity. Additional initiatives include service centralisation and flexible working arrangements to enhance efficiency and workforce stability. **Conclusion**: Action implemented as agreed.

Records Management (non-acute health) (2024/25): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
5.1	**Improving Guidance and Compliance in Records Retention and Disposal** Guidance on the retention and appropriate destruction of records should be provided.	Head of Health Records & Clinical Coding Deputy Head of Occupational Therapist Deputy Medical HR Manager December 2024	**High**	Guidance on records retention and destruction has been reissued and published on the intranet, supported by updated communications aligned to the Records Management Code of Practice 2022. This provides clearer direction to staff on retention requirements and supports improved consistency in practice. **Conclusion**: Action implemented as agreed.

Speaking Up Safely (2024/25): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1.1	**Enhancing Strategic Oversight and Delivery of the Speaking Up Safely Action Plan** The action plan should be revisited to ensure that actions remain appropriate, reflect recommendations from the Guardian Service annual report, and include clearly assigned responsibilities and realistic timescales.	Director of Workforce & OD 31 March 2025	**High**	The action plan has been refreshed, with incomplete actions carried forward into a revised 2025/26 plan. The updated plan includes clear ownership and timelines, incorporates Guardian Service recommendations, and is subject to ongoing monitoring and approval through the Speaking Up Safely Working Group and Workforce and Organisational Development Committee. **Conclusion**: Action implemented as agreed.
3.2	**Strengthening Organisational Reporting and Learning from Speaking Up Safely Concerns** Service Groups should consolidate information on concerns raised (including themes, trends, actions taken, and lessons learned) and report this to an appropriate Board-level committee to support organisation-wide understanding. Reporting should also provide assurance on compliance with policy requirements, including timescales.	Service Group Directors October 2025	**High**	A structured, centralised reporting framework for Speaking Up Safely has been established, incorporating rotational service group reporting of themes, trends and actions to governance forums. Reports are now consolidated and presented to Workforce & OD groups and Committee, strengthening organisational oversight and assurance, with full service group participation scheduled. **Conclusion**: Action implemented as agreed.

Tertiary Services (2024/25): Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
8	**Reporting and Escalation within the Health Board** While Regional and Specialised Services Provider Planning Partnership (RSSPPP) provides quarterly reports to Board, reporting could be strengthened to include clearer updates on progress, risks and issues affecting programme delivery. Governance arrangements include reporting to Management Board; however, regular reporting has been limited, and there has been no routine reporting at committee level.	Associate Programme Director for Tertiary & Specialist Services Planning Partnership December 2024	**High**	Reporting has been strengthened through enhanced governance arrangements, including the introduction of "Four A's" reports to Management Board, providing regular escalation of key issues. Quarterly Board reporting now include improved coverage of priorities, risks and mitigating actions, supporting more effective oversight and assurance of programme delivery. **Conclusion**: Action implemented as agreed.

Morriston Hospital – Burns / ICU (Phase 1) (2024/25): Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
5.1	**Approvals by the Board** Retrospective approvals were required for project changes to align with the requirements of the Project Execution Plan.	N/A Actioned since audit fieldwork.	**High**	Retrospective approval of Project Manager Instructions (PMIs) was formalised through Project Board, with detailed schedules (including reference, description and value) presented and recorded in minutes. Subsequent meetings evidence strengthened governance arrangements, with approvals clearly documented and all PMIs and requests for change (RFCs) reviewed, approved and formally closed in line with requirements. **Conclusion**: Action implemented as agreed.

Acute Medical Services Redesign Programme (2024/25): Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1	**Benefits Realisation Framework** The Health Board did not have a formal benefits realisation framework or guidance to support the identification and measurement of benefits. Review of the AMSR Programme benefits register identified gaps, including benefits without defined measures, lack of baselines or targets, and absence of assigned ownership and timescales.	Deputy Director of Planning and Partnerships September 2025	**Medium**	A formal Benefits Realisation Framework has been developed, providing clear guidance on identifying, measuring and assigning benefits. The framework has been approved and integrated into the Health Board's investment review process, supporting consistent application, defined ownership, and improved ability to track outcomes, performance and value for money across programmes. **Conclusion**: Action implemented as agreed.

Data Quality (2024/25): Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
3	**Information Governance Learning & Operational Group TOR** The Terms of Reference (TOR) for the Information Governance Learning & Operational Group (IGLOG) were incomplete and in draft form, and did not reflect the current governance structure or reporting arrangements.	Assistant Director of Digital Services - Business Management and Information Governance April 2025	**Medium**	The IGLOG Terms of Reference have been updated, finalised and formally approved. The revised ToR clearly reflects current governance structures and reporting routes, including alignment to the Digital, Data and Research Innovation Committee, providing improved clarity of roles, responsibilities and oversight arrangements. **Conclusion**: Action implemented as agreed.

Estates Assurance (2024/25) – Energy Management: Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1	**Energy themed reporting** While energy reporting was being developed within the Health Board, this could be strengthened through more comprehensive inclusion of key issues and updates from relevant forums (e.g. WEOG/WEG), particularly in relation to the decarbonisation agenda.	Technical Services Officer – Energy & Carbon February 2025	**Medium**	Energy reporting has been enhanced through Estates Technical Services reports, which now include key issues, risks and operational updates, including input from relevant forums. These improvements provide greater visibility of energy performance and support monitoring, assurance and informed decision-making aligned to the decarbonisation agenda. **Conclusion**: Action implemented as agreed.

Fertility Service (2024/25): Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1	**Completion and Oversight of Audit Plan.** Testing identified delays and inconsistencies in audit delivery, including issues with timeliness, quality assurance and follow-up of findings.	Quality Manager January 2025	**Medium**	The audit plan has been reviewed and updated to reflect the current control environment. A revised 2025–2026 plan has been approved, including changes to audit frequency and improved monitoring arrangements. Oversight through governance meetings supports improved timeliness, consistency and follow-up of audit activity. **Conclusion**: Action implemented as agreed.

Job Evaluation (2024/25): Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
2	**Bilingual Job Descriptions** Testing identified instances where bilingual job descriptions were not available, which is not fully aligned with Welsh Language Standards requirements.	Assistant Director of Workforce July 2025	**Medium**	Compliance has been strengthened through the introduction of a structured translation process and supporting toolkit, alongside clear guidance to recruiting managers. Monitoring has been enhanced through analytical review of job descriptions and reinforced communications, improving consistency and adherence to bilingual publication standards across recruitment processes. **Conclusion**: Action implemented as agreed.

Primary Care Cluster Plans (2024/25): Reasonable Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status, Updated Responsibility and Timescale
1.1	**Attendance at Primary Care Cluster meetings** Alternative representation should be in place where members are unable to attend, and this should be clearly recorded.	Pan Cluster Planning Group Chair (Deputy Group Medical Director) November 2024	**Medium**	Attendance expectations have been reinforced, with formal deputies nominated where required. Evidence demonstrates that deputy representation is in place, supporting continuity of attendance and effective participation in meetings. **Conclusion**: Action implemented as agreed.
1.2	**Recording of Meeting Attendance** Attendance records should clearly identify non-members.	Pan Cluster Planning Group Chair (Deputy Group Medical Director) November 2024	**Medium**	Attendance records have been enhanced to distinguish between members, deputies, and non-members. This improves transparency and ensures accurate recording in line with governance expectations. **Conclusion**: Action implemented as agreed.

Appendix A: Summary of Status of Findings for Sampled Reports

The following table sets out the status of all findings (based on the health board's recommendation tracker: 31 March 2026) for reports included in the sample reviewed as part of this exercise:

As per original Internal Audit report:				Sample of closed findings at this review		Status of remaining findings as per tracker (31 March 2026)	
Report title	**Assurance rating**	**High Priority findings**	**Medium priority findings**	**High priority findings**	**Medium priority findings**	**High priority findings**	**Medium priority findings**
Safety Notices and Alerts (2021/22)	Limited	1	5	1	1	-	Closed: 3 Overdue: 1
Continuing Healthcare (2022/23)	Limited	6	2	4	-	Closed: 2	Closed: 2
Asset Management	Limited	2	3	1	-	Closed: - Overdue: 1	Closed: 1 Overdue: 2
Business Continuity Management	Limited	3	7	2	-	Closed: 1	Closed: 5 Overdue: 2
Clinical Coding	Limited	3	2	1	-	Closed: 2	Closed: 1 Overdue: 1
Records Management (non-acute health)	Limited	5	3	1	-	Closed: 2 Overdue: 2	Closed: 3
Speaking Up Safely	Limited	5	1	2	-	Closed: 2 Overdue: 1	Closed: 1
Tertiary Services	Limited	2	6	1	-	Closed: 1	Closed: 6
Morriston Hospital – Burns / ICU (Phase 1)	Reasonable	1	6	1	-	-	Closed: 6
Acute Medical Services Redesign Programme	Reasonable	-	7	-	1	-	Closed: - Overdue: 6
Data Quality	Reasonable	1	4	-	1	- Overdue: 1	Closed: 2 Overdue: 1
Estates Assurance – Energy Management	Reasonable	-	5	-	1	-	Closed: 4
Fertility Service	Reasonable	-	1	-	1	-	-
Job Evaluation	Reasonable	-	5	-	1	-	Closed: 1 Overdue: 3
Primary Care Cluster Plans	Reasonable	1	4	-	2	Closed: - Overdue: 1	Closed: - Overdue: 2
		30	**61**	**14**	**8**	**Closed: 10 Overdue: 6**	**Closed: 35 Overdue: 18**

Appendix B: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	**Substantial**	**Follow up:** all recommendations implemented and operating as expected.
	**Reasonable**	**Follow up:** all high priority recommendations implemented and progress on the medium and low priority recommendations.
	**Limited**	**Follow up:** no high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	**Unsatisfactory**	**Follow up:** no action taken to implement recommendations.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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