Improving quality governance

Velindre University NHS Trust

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About us

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Contents

Audit snapshot 4
Key facts and figures 6
Our findings 7
Appendices 17
1 About our work 18
2 Previous recommendations 21
3 Management response 23
4 Key terms in this report 33

Audit snapshot

What we looked at

1 Our review assessed progress made by Velindre University NHS Trust (the Trust) in implementing our 2022 review of quality governance recommendations.

2 Our review also considered progress made by the Trust to implement corporate arrangements to meet the new Duties of Quality and Candour, and related oversight and scrutiny. This review covers arrangements at the core Trust only[1] and excludes its hosted bodies.

Why this is important

3 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' before anything else is one of the core values underpinning the NHS in Wales. Poor quality healthcare can be costly in terms of harm, waste, and variation.

4 During 2021-22, the Auditor General reviewed quality governance arrangements across all health boards and trusts in Wales. Our 2022 Review of Quality Governance at the Trust found that it was committed to improving its quality governance arrangements. But, whilst we found that arrangements were effective at the time, the Trust could have coordinated them better to ensure consistency and sharing of learning.

5 We made 12 recommendations, covering six areas, which focused on:

- providing SMART[2] actions for quality priorities;
- improving monitoring and scrutiny of strategic risks;

[1] Velindre Cancer Service, Welsh Blood Service, and the Corporate Division.
[2] Specific, measurable, achievable, relevant, and time-based.

- improving the information and discussions on corporate risks;
- understanding and taking action on staff survey findings;
- improving the flows of quality and safety assurance; and
- improving the timeliness of quality and safety performance information.

6 We set out the recommendations in full in **Appendix 2**.

7 In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty placed on NHS bodies to secure system-wide quality improvements. It also places a Duty of Candour on NHS bodies, requiring them to be open and honest with service users when things go wrong and apply lessons learned.

What we have found

8 The Trust has implemented all but one of our 2022 audit recommendations in full, with notable progress made on the one remaining recommendation still in progress. Significant improvements are evident in the Trust's approach to quality and safety assurance, the establishment of clear quality priorities, and the timeliness of quality and safety information.

9 The Trust is making progress to understand staff experience and has developed frameworks and initiatives to enable staff to support to speak up safely.

10 The Trust has made significant progress to improve the information on the operational risks that is presented to meetings. The improvement in information supports good challenge and scrutiny of risks.

11 The Trust has made significant progress in implementing its statutory duties on quality and candour.

What we recommend

12 We have made no new recommendations in this report.

Key facts and figures

- All but one of the actions arising from the 2022 recommendations that we reviewed are complete.
- Ten ‘moderate harm and above’ incidents have needed the application of the Duty of Candour procedure during 2024-25.[3]
- The response rate of the NHS Staff Survey 2024 at the Trust was 34% (NHS Wales rate 22%).
- The Trust set 18 quality priorities for delivery in 2025-26.
- Internal Audit’s report on the Duty of Quality (published May 2025) gave the Trust a Reasonable Assurance rating.
- Internal Audit’s report on the Duty of Candour (published May 2025) gave the Trust a Substantial Assurance rating.

[3] Moderate harm within the context of the Duty of Candour is defined as a patient safety incident that results in a moderate increase in treatment and significant, but not permanent, harm.

Our findings

Implementation of previous recommendations

The Trust has fully implemented eleven of our twelve recommendations but needs clearer outcome definitions and success measures are required for some quality priorities

The setting of quality priorities

13 Most of the Trust’s 2025-26 quality priorities are specific, measurable, achievable, relevant, and time-based (SMART), but the intended outcomes and success measures could be clearer for some priorities.

14 To inform the development of the quality priorities, the three quality hubs (see **paragraph 32**) identified improvement themes by triangulating incident data, concerns, service-user feedback, and relevant Welsh Government guidance and Welsh Health Circulars. Using these themes, the Quality, Safety and Assurance Team drafted initial priorities which included all incomplete quality priorities from the previous year. Input was also sought from the Velindre Cancer Service (VCS) Patient and Carer Partnership Group, who had strong views that communication with patients should be a theme.

15 Internal Audit’s May 2025 Duty of Quality Report highlighted that some priorities were not fully SMART or lacked clear measures, as a result the Trust made changes. The quality hubs reviewed the revised priorities, and the Integrated Quality and Safety Group (IQSG) endorsed the final set. The Board approved the resulting 18 quality priorities for 2025-26 in its May 2025 meeting.

16 The Trust's quality priorities fall into four themes:

- Improve patient and donor communications.
- Strengthen quality and safety infrastructure.
- Improve patient and donor safety.
- Improve opportunities to gather and learn from people's feedback.

17 For each theme, the Trust has identified the actions it will take to improve performance. There is clarity on the timescale for delivery for most but not all priorities. There is still scope for the Trust to be clearer about the intended outcomes, and to set out clearly how success will be measured for some priorities. For instance, it is not clear how the Trust will measure whether:

- it has achieved a strengthened quality and safety culture across the organisation;
- ensured all staff involved in an incident have received feedback and support: and;
- identified improvements to service user mechanisms are achieving desired outcomes.

18 In previous years, reporting of progress to deliver quality priorities and associated achievement of desired outcomes was reported only to IQSG. However, at the time of our fieldwork, the Trust was considering whether to also report progress to the Quality, Safety, and Performance Committee.

Risk management

19 The Trust has made sustained and demonstrable improvements to Board and committee level risk oversight, the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). Risk information has improved and there is clearer executive ownership of risks. There is a positive trajectory of governance maturity, despite opportunities for further refinement.

20 The Trust's Board, Audit Committee, Quality, Safety and Performance, and Strategic Development Committees received the full BAF at each of their meetings during 2024 and 2025. We have seen good challenge and scrutiny of the BAF controls and sources of assurance in meetings, with Trust officers providing appropriate responses. Similarly, we have also seen scrutiny of the progress to address gaps in controls and sources of assurance.

21 In our 2025 Structured Assessment report, we discuss the progress the Trust is making to refine the BAF. In that report we suggest that the Trust should consider allocating specific strategic risks to each committee to review, rather than each committee reviewing the full set.

22 The Trust began work in late 2024 to review and improve the content and format of operational risk registers and the CRR. The Governance, Assurance, and Risk Group led the review, informed by Independent Members. In our 2025 Structured Assessment report, we found that the CRR now consistently includes opening, current, and target risk scores and the mitigating actions either underway or planned. However, we recommended that the Trust should improve risk management tracking by ensuring that all actions in the CRR have SMART target dates.

23 In Board and committee meetings, when discussing risks in the CRR, Executive Directors cross reference other agenda items or meetings that are relevant. Board and committee CRR cover reports show whether papers have been previously scrutinised by other committees or by the Executive Management Board. Summaries typically provide a reasonable outline of prior discussions and resulting actions planned or completed.

24 Since our 2022 Quality Governance Review, there has been significant improvements in discussions on corporate risks at Board and committee meetings, with Executive Director/Director risk owners leading discussions on risks in their areas of their responsibilities. Discussions now focus on the content of the risks themselves, rather than the format of the registers.

Staff feedback

25 The Trust uses multiple staff feedback mechanisms to inform targeted actions on culture, wellbeing, and psychological safety, though many initiatives are still at an early stage and the impact is still emerging.

26 The Trust gathers staff feedback through formal and informal mechanisms to understand their experience, including:

- the NHS Staff Survey;
- Speaking Up Safely Sessions;
- InConfidence Platform;
- staff concerns;
- 15-step Challenges; and
- staff exit Interviews.

27 During 2025, the Trust committed to a programme of work to understand and improve staff experience. Analysis of staff surveys and related workforce data has informed targeted actions aimed at improving psychological safety and supporting reflective practice. The Trust has committed to understanding the root causes of staff concerns and to use learning to support positive cultural change; however, the impact of these actions is still emerging.

28 In January 2025, the Quality, Safety, and Performance Committee received a report on bullying, harassment, and discrimination, drawing on the 2023 NHS Staff Survey, the Workplace Race Equality Standard, and employee relations data. While the review concluded that reported levels were lower than the NHS Wales average, it acknowledged that these are still active areas requiring ongoing vigilance. The Trust developed an action plan, aligned with its Strategic Equality Plan 2025–26 Action Plan.

29 Following receipt of the 2024 NHS Staff Survey results, the Trust set up a dedicated Staff Survey Group to analyse results and coordinate improvement actions. Divisional groups were tasked with developing targeted interventions. Analysis found three priority areas: psychological safety, teamwork, and the effectiveness of Performance Appraisal and Development Reviews (PADRs), and an action plan was developed. In response to the survey findings, positively, the Trust appointed a Well-being Co-ordinator and Wellbeing Champions to provide peer support, with the co-ordinator working with the Staff Psychologist to align programmes of work.

30 The Strategic Equality Plan 2025–26 sets out actions to support the development of a positive organisational culture. Key actions include reviewing the effectiveness of Speaking Up Safely arrangements and gathering feedback from Staff Networks on their lived experience of working within the Trust. However, the Trust needs to further clarify how feedback will be translated into sustained behavioural and cultural change across the organisation. During 2025, the Trust also developed a Culture Framework with a supporting action plan covering:

- Compassionate leadership;
- Psychological and physical well-being;
- Diversity and inclusion;
- Values and behaviours; and
- employee voice.

31 The Trust has promoted Speaking Up Safely arrangements with staff. There are structured listening exercises to provide senior leaders with insight into staff concerns and perceptions of organisational culture. At the time of our review, a further awareness-raising campaign was planned. The Trust acknowledged that some staff find it difficult to raise concerns in a small organisation and that further work is needed to strengthen staff confidence in using these mechanisms. Further work is also needed to set up processes to turn lessons learned into actions. The InConfidence platform, which enables staff to raise concerns anonymously, was relaunched in 2025 following reduced levels of use.

32 During 2025, the Trust has also progressed a programme of initiatives to embed Compassionate Leadership principles through training and guidance. These principles are intended to form part of a developing staff engagement framework, although implementation is still at an early stage.

33 Staff health and well-being work at the Trust is monitored via the Healthy and Engaged Steering Group. The Quality, Safety, and Performance Committee receives regular workforce reports. Reports received during 2025 include staff feedback, and analysis and learning. Reports also included updates on the Staff Survey Action Plan, the Healthy and Engaged Workplan, the Strategic Equality Plan, and the Culture and Inclusion Action Plan.

34 In 2025, the way the Trust conducted a reorganisation of the management structure in VCS led to concerns being raised by a small group of staff that were specifically impacted by the exercise. The Trust took appropriate action to understand staff concerns by commissioning an independent listening exercise. The exercise led to the development of an appropriate and proportionate action plan to understand and respond to the concerns raised by staff. The Trust has set out a programme of work over twelve months up to June 2027 to develop a positive culture from floor to Board, and to better manage change and poor behaviours.

35 It is clear that the Trust is committed to understanding and improving culture, behaviours, inclusivity, and staff psychological well-being. Collectively, the action plans developed through 2025 and 2026 (discussed above) are positive and appropriate. The Board has received numerous papers at committee and Board meetings through 2025 and 2026 on work to understand and improve staff experience and related actions plans. However, there is a need to ensure, from a governance and assurance perspective, that there is clarity on the totality of work underway, progress and impact. The Board is committed to changing its committee structure in 2026 to provide more space for consideration of, and assurance on, workforce matters.

Quality and safety assurance

36 The Trust has strengthened the flow of quality and safety assurance with a well-defined structure and hierarchy supporting focused discussion, monitoring, and scrutiny. In 2022, the Trust set up three divisional quality hubs (the hubs):

- Corporate Quality Hub;
- VCS Quality Hub; and
- Welsh Blood Service (WBS) Quality Hub.

The hubs were created specifically to provide oversight to ensure the Trust meets requirements under the Duties of Quality and Candour.

37 Membership of the hubs is appropriate, including the leads for quality, safety, and user experience, as well as corporate assurance functions. The Corporate Quality Hub also includes leads for risk, safeguarding, health and safety, claims, redress, information governance, and workforce.

38 The hubs meet monthly, using a standard template populated with 12-month trend data plus information on risks, audits, workforce, health and safety, and information governance. Meetings are informal and not minuted, but key decisions and escalations are formally recorded.

39 The Corporate Quality Hub combines and triangulates information from the VCS and WBS quality hubs and determines what should be escalated to the Trust-wide IQSG.

40 Also created in 2022, the IQSG provides strengthened operational oversight for quality and safety matters. The IQSG, which meets monthly, is chaired by senior clinical executives and has appropriate membership. It reports to the Executive Management Board through highlight reports and also escalates issues to the Board’s Quality, Safety, and Performance Committee on an exception basis. IQSG meeting discussions and decisions inform the quarterly Quality and Safety Report received by the Quality, Safety, and Performance Committee.

41 VCS and WBS continue to run separate divisional quality and safety groups. These two groups have broader representation and a wider remit than the hubs. The purpose of the quality and safety groups is to enable more detailed, division-specific discussions on quality and safety matters and associated risks. The WBS Quality and Safety Group meets monthly, while the VCS Quality and Safety Group meets every two months. The quality and safety groups both report to their respective divisional leadership teams and the IQSG. The restructure of the VCS management team in 2025 led to changes to the membership of the VCS Quality and Safety Group. There are also plans to increase the VCS Quality and Safety Group meeting frequency. The Trust says that it is monitoring the ongoing need for the quality hubs and may opt to disband the VCS and WBS hubs if it deems them surplus to requirements.

Timeliness of quality and safety information

42 The Trust has improved the timeliness of quality and safety data reported to the Quality, Safety, and Performance Committee.

43 The Trust's corporate Quality, Safety, and Assurance Team ensures that quality hubs receive timely quality and safety metrics for discussion. Quarterly quality and safety reports bring together up-to-date quality metrics, performance data, and user experience measures from across the Trust, supported by narrative explaining trends, performance, and learning. The reports are informed by the discussions and intelligence generated at IQSG meetings.

44 At the time of our 2022 review, the Quality, Safety, and Performance Committee had received at least six different quality, safety, and user experience reports. However, many of those reports were too operationally detailed. Incorporating the information into a single quarterly report has now enabled the Trust to present timely information pitched appropriately to the Committee's role and needs.

Responding to the Duties of Quality and Candour

The Trust has made significant progress in implementing its statutory duties on quality and candour

45 The Trust has articulated a clear approach to the implementation of both statutory duties. It set up dedicated implementation groups to oversee and coordinate compliance activities. The Trust completed the national self-assessment for both duties and reported the findings to the Quality, Safety, and Performance Committee.

46 Quality governance reporting includes updates on implementation. Integrated Medium-Term Plans and other strategic documents also explicitly reflect the quality domains of the Duty of Quality.

47 Board members have received development sessions to help them understand their responsibilities under both duties. The Trust has provided staff training, via e-learning interactive sessions. At the time of our review, there was a higher completion rate for Duty of Quality training compared to Duty of Candour training. The IQSG receives monthly reports detailing training completion rates. Plans are in place to expand training, to include face-to-face delivery, to further support staff understanding and increase compliance rates.

48 The Trust has clearly defined leadership responsibilities for the duties. The Executive Director of Nursing and Allied Health Professionals leads on both statutory duties. Senior divisional leads and corporate quality leads are actively involved in operational delivery. There is strong executive sponsorship of organisational culture mechanisms such as Speak Up Safely, and staff are using the quality framework to shape presentations, performance discussions, and assurance reports.

49 New quality governance structures, the IQSG, and the three quality hubs have strengthened and clarified the flows of quality assurance from ‘floor to board’. Reporting and escalation mechanisms are clear and effective.

50 There are clear policies and procedures covering the requirements of the duties. The Trust’s Quality Management System and regulatory tracker support compliance with the Duty of Quality. The Trust actively identifies and implements actions to reduce the risk of Duty of Candour incidents recurring. Lessons learned and good practice are actively shared. Duty of Candour cases are infrequent, and each case is carefully managed. In 2024-25, the Trust reported ten ‘moderate harm and above’ incidents needing the application of the Duty of Candour procedure.

51 The 2024-25 Annual Quality Report provides a good summary analysis of quality and candour information for the year. The quarterly Quality and Safety Report provides an appropriate range of quality information and progress updates to the Quality, Safety, and Performance Committee, and leadership and executive teams.

52 During 2025, Internal Audit reviewed the Trust’s compliance with both duties. Internal Audit provided reasonable assurance for its Duty of Quality review, and substantial assurance for its Duty of Candour review.

53 The Trust has been transparent about outstanding actions needed to meet the duties, specifically the need to develop further quality metrics and to develop an ‘always on’ quality dashboard.

Appendices

1 About our work

Scope of the audit

We have assessed whether:

- the Trust has implemented previous audit recommendations arising from our 2022 review of its quality governance arrangements and is realising the intended outcomes and benefits of those recommendations; and
- there is a sound corporate approach to oversee and scrutinise the quality and safety of services in line with the Duty of Quality and Duty of Candour requirements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Has the Trust set appropriate Quality Improvement Goals/objectives?
- Has the Trust strengthened strategic risk information and scrutiny arrangements?
- Has the Trust strengthened corporate risk information and scrutiny arrangements?
- Does the Trust have effective arrangements in place to capture feedback from staff and to review and address findings?
- Do the Trust's arrangements support appropriate flows of quality and safety assurance?
- Is the quality and safety information received by the Quality, Safety and Performance Committee timely?
- Has the Trust taken steps to implement the duty of quality and duty of candour?

Criteria

In gathering evidence against the above questions, we were looking for the Trust to demonstrate that it:

- has made the expected progress in implementing our 2022 audit recommendations (set out in **Appendix 2**) to address the issues and concerns identified in the original audit; and
- was implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) in respect of the duties and quality and candour.

Methods

We undertook our audit work between May and September 2025.

We reviewed the following key documents:

- Quality frameworks;
- Relevant interval audit reports;
- Staff feedback and engagement;
- Risk Registers and reports;
- Integrated Medium-Term Plan;
- Policies;
- Previous Audit Wales reports; and
- Board and Quality, Safety and Performance Committee papers.

We interviewed the following:

- Executive Director of Nursing, Allied Health Professionals and Health Science;
- Executive Director of Organisational Development and Workforce;
- Director of Corporate Governance (Interim);

- Quality, Safety and Performance Committee Chair;
- Head of Quality, Safety and Performance; and
- Deputy Head of Quality, Safety and Performance

We also asked the Trust to complete and submit a self-assessment, setting out its view of progress against the 2022 recommendations. The Trust submitted a completed self-assessment on 27 May 2025.

2 Previous recommendations

We made the following recommendations in 2022. We have highlighted the status of these recommendations based on our follow up review.

R1 The Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions (**in part**).

R2 As soon as possible, the Trust should ensure that each committee incorporates regular reviews of the strategic risks assigned to them within their cycles of business and:

2.1 Provide appropriate consideration of the controls and sources of assurance (**complete**).

2.2 Scrutinise progress to address gaps in controls and assurances (**complete**).

R3 The Trust should:

3.1 Determine what information is needed in operational risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action (**complete**).

3.2 Ensure that when risks appearing in the Corporate Risk Register have been discussed in other Board and committee agenda items, suitable cross references are provided (**complete**).

3.3 Ensure executive risk owners (or an appropriate nominee) lead discussions on risks within their areas of responsibility (**complete**).

R4 The Trust should progress work to develop the action plan to address findings from the NHS Staff Survey including:

4.1 Understanding why some staff feel that the Trust does not take effective action to deal with bullying, harassment, or abuse (**complete**).

4.2 Understanding why some staff may feel that the Trust does not act adequately to address staff concerns (**complete**).

R5 In operationalising the Trust's new Quality Hubs, the Trust should:

5.1 Ensure that the remit for each group avoids unnecessary duplication of coverage with other new and existing quality groups (**complete**).

5.2 Ensure that attendees of quality meetings are appropriate and provide adequate representation of relevant disciplines (**complete**).

5.3 Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines for assurance (**complete**).

R6 The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee is as up to date as possible, covering agreed time periods (**complete**).

3 Management response

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should strengthen the Digital and Data Plan by setting clear milestones and resource requirements, defining and tracking digital maturity, and fully integrating digital priorities across workforce, estates, finance, and clinical service planning. **(Paragraphs 12-14)**	The Health Board has procured a Strategic Partner to support the development of a comprehensive Digital & Data Plan aligned to the Health Board's Strategy. A Strategy Deployment Framework has been approved that identifies the cross-cutting enablers and appropriate governance route. A 12-week programme of work to complete the plan has commenced led by the Chief Clinical Information Officer. This plan will identify clear milestone deliveries for 2026/2027 that will be monitored via Executive Management Board and Board oversight via Operational Delivery Committee. The plan will take into account workforce and financial requirements.	Approval by EMB in August 2026 Approval by Board in September 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		The Digital and Data Enabling Plan demonstrates the plan for the Digital and Data Delivery Plan. Assessments of Digital Maturity will be performed as part of programmes of work by the Business Change team. The plan will be agreed at the September 2026 Board.		
R2	The Health Board should strengthen its digital performance reporting by including clear milestones, progress measures, risk updates and consistent information across programmes, supported by simple visuals to improve Board oversight. **(Paragraph 20)**	Aligned to the Strategic Deployment Framework, Digital & Data Delivery Plan progress will be reported as part of routine reporting arrangements and will include clear milestones, progress measures, risk updates and consistent information across all programmes. The Digital and Data Enabling Plan provides a high-level visual of the ambition. Over the 12-week period further visuals will be developed to improve Board oversight.	September 2026	Director of Digital & Data
R3	The Health Board should develop a comprehensive, costed infrastructure replacement plan that includes clear timelines, milestones, asset information and long-term investment needs, supported by clearer reporting	A 1-year costed replacement programme is approved in alignment with the allocated discretionary capital for Digital & Data. This approval is gained from the Executive Capital Management Group and onwards to EMB. The Capital Plan is also reported to the Operational Delivery Committee.	December 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	on the effectiveness of controls and actions. **(Paragraph 24)**	Pipeline Infrastructure Replacement is planned and prioritised as in year capital opportunities arise. Allocations are tailored to schemes based on risk, deliverability and available funds. An infrastructure replacement programme will be developed for subsequent years, aligned to the Digital & Data Strategic Delivery Plan, noting that anticipated increases in infrastructure costs will be estimates prior to procurement.		
R4	The Health Board should develop a clear AI governance framework, ensuring all AI activity is formally recorded, risk-assessed and reported through the Board Assurance Framework and Organisational Risk Register. **(Paragraph 31)**	A draft AI Strategy & Policy has been produced and is in its final review prior to circulation for approval. All technologies (including AI technologies) are subjected to our Data Protection Impact Assessments and Cyber Security Impact Assessment Processes. An inventory of all AI activity is captured through our cyber assessment process for new programmes of work. The Board Assurance Framework and Organisational Risk Register will be updated to ensure risks regarding AI will be captured. The BAF will be updated for the July 2026 Board. Formal approval of Policies and Procedures will be completed by Autumn 2026	September 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5	The Health Board should develop a structured approach to understanding and building its digital workforce capability by:			
R5.1	maximising the use of HEIW's Digital Capability Framework to understand the basic IT confidence of staff and developing a local assessment tool to understand the wider digital transformation skills needed to deliver its digital ambitions. **(Paragraph 32)**	The Health Board already has an established Digital & Data Clinical Network, that is multi-disciplinary by design. This group assesses capabilities on a programme-by-programme basis. The Digital Transformation function performs an assessment of capabilities as new programmes of work are moved into implementation. These assessments form the backbone of training plans for new programmes of work. These processes are embedded into how digital and data change is delivered. Our process for the Business Analysts ensures information gathering and baselining of workflows is standardised. The objective is to ensure a consistent approach so that everyone is measuring the same things in the same way. The high-level process actions and dependencies include:	March 2027	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Set the scope & stakeholders • Agree the scope and relevant care groups and identify and agree stakeholders for engagement. Establish the workforce baseline • Confirm the workforce profile and WTE in post with the care groups (including part-time working, sickness absence, annual leave, etc.) Map the current workforce process • Understand what staff do, when they do it, and how they do it (paper vs digital). Estimate time spent per activity using observation studies and data reports, and agree appropriate metrics (e.g. percentage of role time, hours per week, or WTE consumption by task) Identify inefficiencies • Highlight high-effort, low-value activities Map demand against capacity • Align activities with demand volumes such as calls, appointments, letters, referrals, and backlogs Identify pressures & constraints • Understand peaks and pressure points, backlogs and queues, and areas that are persistently in deficit Validation with Services • Agree the baseline and measures with services, with clear ownership by the service lead		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Future development of this work will ensure a Health Board wide adoption of the HEIW Digital Capabilities Framework. The Health Board will develop a local assessment tool and digital skills training programme to assess and build digital transformation skills and capability across its wider workforce.		
R5.2	developing a digital skills training programme, ensuring staff have access to targeted, role-specific learning beyond basic e-learning, including data skills, digital change capability, and transformation skills. **(Paragraph 33)**	As per response to R5.1.	March 2027	Director of Digital & Data
R5.3	creating a strategic digital workforce plan that sets out required staffing levels, roles, competencies, and future capacity needs, informed by a clear baseline of current digital workforce capability. **(Paragraph 34)**	In alignment with R1, a comprehensive Digital & Data Strategic Delivery Plan will incorporate workforce requirements	September 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6	The Health Board should develop an organisation-wide approach to user engagement and digital inclusion by:			
R6.1	introducing an engagement framework to ensure staff and service users are routinely involved in the design and development of all digital programmes. **(Paragraph 35)**	The Digital Clinical Network is a core stakeholder group that will test the design and development of the Digital & Data Plan. Engagement on the development of the plan will be reported to the Improving Care Board, Strategic Development Committee and Public Board. Through our Deployment Framework, engagement with Service Users forms a core part of the digital & data plan. The Digital and Data Enabling Plan outlines how service users will be engaged for the development of the plan. A Digital Inclusion Plan will be developed to complement the wider Digital & Data Plan.	September 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6.2	creating a digital inclusion plan setting out priorities, actions, measures and how digital exclusion risks will be addressed across all service areas. **(Paragraph 37)**	The Digital Transformation function within the Digital & Data Directorate holds the responsibility for digital exclusion, user experience and engagement. New processes are embedded within programme plans and reported alongside the delivery plan. As above in R6.1 a Digital Inclusion Plan will be developed.	March 2027	Director of Digital & Data
R6.3	ensuring that digital exclusion and user engagement activity is clearly reported, with regular updates on actions, progress, and impact to support better oversight and accountability. **(Paragraph 37)**	As above in R6.2 These processes are embedded into business-as-usual activities and reported alongside the delivery plan. Routine reporting on all elements of the digital & data plan will be reported to Executive Management Board and the Sub Committee of the Board.	March 2027	Director of Digital & Data
R7	The Health Board should set out clear, costed investment requirements, including capital needs beyond 2026-27, timelines for key decisions, and the affordability of major digital priorities. This will allow the Board to judge whether its digital	Costed investment requirements will only ever be estimates and subject to procurement processes. These investments requirements will be considered within the Digital & Data Delivery Plan. The Digital and Data Delivery Plan will identify the longer term digital and data requirements / possible investments.	September 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	ambitions are realistic within its financial position. **(Paragraphs 38-39)**			
R8	The Health Board should introduce a coordinated approach to overseeing all digital projects to clearly assess progress and dependencies across local, regional and national work. **(Paragraphs 41 and 46)**	As the Digital and Data Strategic Delivery Plan moves from development to implementation, progress will be routinely reported. This plan will be a comprehensive portfolio of work that incorporates, local, regional and national programmes. Local, Regional & National Programmes will continue to have oversight from the Executive Management Board and Board Sub Committees. A new Regional Digital & Data Workstream will provide further oversight and reporting to the South East Wales Regional Joint Committee.	December 2026	Director of Digital & Data
R9	The Health Board should complete and embed its benefits framework, ensuring that benefits registers are routinely maintained and reported to demonstrate whether digital investments are delivering improvements, value for money and	In the Autumn of 2025, the Digital & Data team recruited a new role, Head of Business Change. This role has been tasked with creating a suite of processes and procedures to ensure benefits are robustly managed for all Digital & Data related programmes.	December 2026	Director of Digital & Data

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	better use of resources. **(Paragraph 47)**	Benefits registers are created for digital transformation programmes of work and will be reported to Executive Management Board and Sub Committees of the Board.		

4 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework sets out the risks linked to the organisation’s strategic objectives, and the controls and assurances in place to manage those risks.
Corporate Risk Register	A Corporate Risk Register sets out the organisation’s significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Datix Cymru	The official Once for Wales Concerns Management System is a secure, cloud-based digital platform used by all NHS Wales staff to report incidents, risks, and safety concerns under the Duty of Candour.
Duty of Candour	The Duty of Candour is a legal requirement for Welsh NHS bodies to be open and honest with service users when harm occurs during their care. This includes communicating with the patient, investigating the incident, and learning from it to prevent future occurrences.
Duty of Quality	The Duty of Quality is a legal obligation on Welsh NHS bodies to continually improve the quality of healthcare services and outcomes for the people of Wales. The Duty requires a focus on quality in all strategic decisions and ongoing monitoring of progress in quality improvement.
InConfidence	InConfidence system in the NHS refers to WorkInConfidence, an anonymous, two-way conversation platform used by staff to raise concerns, provide feedback, or report incidents without disclosing their identity.

Integrated Medium-Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to Welsh Government for approval.
Integrated Quality and Safety Group	A Trust-wide quality and safety group.
Quality governance	The combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Quality, Safety and Performance Committee	The QSP is a Board committee to help it discharge its functions and meet its responsibilities in relation to: • quality, safety, and performance; • workforce; and • digital delivery and information governance.
Quality Hubs	Quality Hubs are meetings held within VCS, WBS and the corporate divisions to support the Trust in meeting Duty of Candour and Quality requirements.
Speaking up Safely	A cultural framework that aims to create an environment where individuals feel secure and confident to raise concerns about issues such as patient safety, quality of care, and workplace bullying without fear of victimisation or detrimental treatment.
Velindre Cancer Service (VCS)	A division with the Trust, responsible for delivering specialist (non-surgical) cancer services for a population of 1.5 million people in Southeast Wales and beyond.
Welsh Blood Service (WBS)	A division within the Trust that provides blood and transplant services across Wales.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.