Audit Recommendations Tracker ☆

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Audit Acti...	Origin	Report	Report Assurance...	Exec Lead	Original Impleme...	Current Impleme...	Recommendation	Management Action Agreed	Remit Committee	Management Lead	Quarterly Progress Report	Action for LT	Priority	Implementation
516	Internal Audit	Health and Safety	Reasonable assurance	Executive Direct...	30/06/2023	04/06/2026	Management should ensure that all policies and procedures that relate to health and safety arrangements, are updated as soon as possible to ensure that they outline the current processes in place, whilst providing the latest guidance to staff should it be required.	The Estates and Health and Safety Division have a programme of work to update all policies and procedures that need reviewing and updating and are included as part of the Health and Safety workplan. These policies and procedures will continue to be reviewed, updated and approved by the relevant group/ Committee by end of quarter 1 2023/24.	QSIC		March 2026 Update: Further to the January update work continues to completed the review and revision as applicable to the the three policies. Currently still working to the anticipated June extension. January 2026 Update: Further reset of target dates has been necessary due to competing priorities. Reset dates as below - Waste Management: Delays continue to have been experienced with the finalising of the policy and the procedure. The previously target publication date agreed by the Division with the Directorate's Governance & General Manager for a publication timeline of 31 December was not achieved. A reset publication date is now planned for March 31st Bomb Threat and Suspicious Packages Procedure – delays continue to have been experienced with the finalising of the procedure. The proposed publication date agreed by the Division with the Directorate's Governance and General Manager to reset publication timeline of 31 December was not achieved. Support has been sought from the Emergency Preparedness & Response Team with the procedure's completion, and a reset publication date is now planned for March 31st Security Procedure - delays continue to have been experienced with the finalising of the procedure. The proposed publication date agreed by the Division with the Directorate's Governance and General Manager to reset publication timeline of 31 December was not achieved. Support has been sought from the Emergency Preparedness & Response Team with the procedure's completion, and a reset publication date is now planned for March 31st In the light of these dates an extension is requested to 30 June 2026 to submit the above for approval. ...	None - Action in Dat	Medium	Green
624	Internal Audit	Duty of Candour	Reasonable assurance	Nursing, Quality...	31/01/2025	30/06/2026	The Trust should create a guide for managers and reviewers to follow for DoC consideration, especially with regard to assessing harm correctly, completing their initial review, and properly recording these on the Datix system.	The Trust will develop a guide for incident managers to support them with the initial review and actual levels of harm for incidents recorded as moderate. The Trust will also formalise the procedure for the meeting between the service area and PTR team should a moderate incident be recorded.	QSIC	Jacqui Westmoreland - Quality and Safety and Putting Things Right Manager	February 2026 update: The guide has been developed to support the PTR team and the organisation on what process to follow for a moderate or above incident. As per the below update this will need to be rewritten into the new policies and procedures to align with the revised regulations which will be implemented in April 2026. Action on track for the 30th June 2026 deadline. October 2025 Update: Following the publication of the Listening to People regulations in October 2025, all associated policies and procedures are currently being reviewed and updated to align with the new guidance. As part of this process, a formal in-person meeting will be scheduled. To ensure the guide and procedure fully reflect the updated regulations and allow sufficient time for the Public Health Wales consultation process, we are requesting an extension until 30th June 2026. August 2025 Update: Guide has been completed and training is being delivered to areas on harm grading and with incident managers for reviewing the initial levels of harm. The incident investigation procedure is currently being updated to reflect the required discussions between service area and the Concerns team surrounding the reporting of a Moderate or above procedure. Request an extention to 30th September 2025. March 2025 Update:...	None - Action in Dat	Medium	Green
626	Internal Audit	Duty of Candour	Reasonable assurance	Nursing, Quality...	31/03/2025	30/06/2026	In order to prevent delays in taking required Duty of Candour actions, procedures that are developed should provide clear guidance on dealing with complex cases where more than one NHS body or another organisation is involved.	The Trust will develop an internal procedure for the management of joint DoC incidents with an internal escalation procedure. PHW will work with the Welsh Risk Pool Duty of Candour Network to request a joint process for investigation and support its development.	QSIC	Jacqui Westmoreland - Quality and Safety and Putting Things Right Manager	April 2026 update: A PHW procedure for the management of joint DoC incidents with an internal escalation process has been developed, so this part of the action is complete. With regards to the second part of the action, PHW have been working with Welsh Risk Pool and the Once for Wales Datix Team to progress joint investigation national procedures at a national level. However, this work has temporarily paused at a National Level due to the priority work for the revised regulations. RAG rating is amber as although the plan is to aim for the 30th June 2026 deadline, as this part of the action is dependent on Welsh Risk Pool and the Once for Wales Datix Team and whether the national work can be restarted in time. February 2026 Update: A PHW procedure for the management of joint DoC incidents with an internal escalation process has been developed, so this part of the action is complete. With regards to the second part of the action, PHW have been working with Welsh Risk Pool and the Once for Wales Datix Team to progress joint investigation national procedures at a national level. However, this work has temporarily paused at a National Level due to the priority work for the revised regulations. RAG rating is amber as although the plan is to aim for the 30th June 2026 deadline, as this part of the action is dependent on Welsh Risk Pool and the Once for Wales Datix Team and whether the national work can be restarted in time. October 2025 Update: Following the publication of the Listening to People regulations in October 2025, much of the planned work has been delayed, to ensure sufficient time is given to embed and roll out the new regulations. As a result, this has been pushed back from the HOPE Network agenda, and will be looked at, at a later date. we are requesting an extension until 30th June 2026, to align to the above action. August 2025 Update: An All Wales Datix module is being developed....	None - Action in Dat	Low	Amber
649	Internal Audit	Health Protection and Screening Services – Performance metrics	Reasonable assurance	National Directo...	30/06/2025	31/05/2026	Reporting timescales The reporting deadlines for submitting information for inclusion in the performance and insight report does not align with the dates for which screening services data is available. As such, there is limited time for appropriate scrutiny and analysis by the divisions and wider directorate. We saw instances where heads of programmes had limited time to extract, collate and summarise the data for inclusion within the performance and insight report. For example, the January 2024 screening services metrics data was not available for scrutiny until the reporting deadline day.	Agreed Action: The Directorate needs to consider the impact of reporting time lags being experienced with some of the metrics, more specifically within Screening. Amendments to the current process need to allow for comprehensive and timely scrutiny of the metrics data at divisional and directorate level prior to being reported to BET/Committees and Board.	ACGC, QSIC	Iain Bell	March 2026 Update: RAG Rating - Amber given the previous delay which has pushed this back to implementation date of 31/05/2026. March 2026 Update: The proposal to shift the reporting timelines around was rejected. The team have reviewed the requirements and proposed an automated way of disseminating the Screening data to the Performance Team (who integrate it into the wider BET dashboard). The intention is to give Screening Leads access to the metrics at the same time so they can scrutinise and investigate under performance. Data availability varies by screening programme, based on the clinical system functionality. Where only have weekend data refreshes are available, we have spoken to system developers to see if additional, first of the month extracts can be scheduled. We will look to pilot the process with the April data release and then full production in May. An extension to 31 May 2026 is therefore requested. February 2026 Update: Extension to 30 April 2026 requested. Actions are underway and the team recommend an amber rating ...	None - Action in Dat	Medium	Amber
652	Internal Audit	Duty of Quality	Substantial assurance	Nursing, Quality...	30/06/2025	30/04/2026	Terms of reference of the Quality Oversight Group (QuOG) The QuOG has a draft ToR. We read the draft ToR and note that the group operates as a structured discussion, oversight, and learning group, with no decision-making or delegated responsibilities. Attendance is not mandatory and so there is no quoracy. There is a risk that without an agreed term of reference, setting out quoracy, the group could experience reduced participation, limiting its ability to meet its objectives. One objective of the group is to ensure active engagement from all directorates/divisions. Furthermore, the draft ToR is not clear on the distinction between 'core' and 'member' attendees. Also, there appears to be a lack of clarity in terms of group oversight, such as through the Business Executive Team (BET) or quality Safety and Improvement Committee. (QSIC). The group does not have an agreed terms of reference which could result in the group not meeting its objectives. Attendees are unsure of their responsibilities under the ToR Actions Are not undertaken in a timely manner and senior management are unaware of the risk.	The QuOG draft ToR will be reviewed and revised to include an agreed quoracy, and to define the responsibilities of core and member attendees as appropriate. We will then appropriately finalise the ToR.	QSIC		April 202 Update: ToR were agreed at QuOG on 25 March 26 and to be taken to BET on 14 April. Cover paper and ToR submitted to BBU for adding to forward look for 14th April on Wed 8 April 26 in line with submission date of 9 April 2026. Discussed with Deputy Board Secretary on 30 Mar 26, who has advised that the action can be closed. February 2026 Update: ToR have been reviewed by the Quality Oversight Group in Q3 and rewritten and discussed at QuOG on 20 Jan 26. A few minor amendments are required following this discussion and to take back to QuOG in Feb 26 for approval. Once this is complete, they will be taken to BET for final review and approval. Action on track for the 30th April 2026 deadline. October 2025 Update: ToR is currently under review by the Quality Oversight Group. Planned agenda item for full review of ToR on 23rd Sept 25 - meeting had to be cancelled due to limited availability. ToR survey designed and distributed to Quality Oversight Group members. Responses collated, analsyed and discussed at Quality Oversight Group meeting on 21st Oct 2025. Further work required and proposals will need to be presented to BET for authorisation. Otherwise, position remains the same as per the August 2025 update. August 2025 Update: ToR is currently under review by the Quality Oversight Group. Planned agenda item for full review of ToR on 23rd Sept 25. Request extension for this action to be extended until 30th April 2026.	Request Action is Cl	Medium	Green

654	Internal Audit	Duty of Quality	Substantial assurance	Nursing, Quality...	30/06/2025	30/04/2026	QuOG remit - Lessons learnt and shared learning Part of the QuOG's remit is to share learning on quality matters. This includes: • Considering relevant quality updates from directorates, divisions, and functions to support improvement and learning. • Identifying and acting on learning from patient safety incidents, concerns, complaints, and claims which, together with good practice are shared across the organisation. • Facilitate the thematic analysis and triangulation of learning from patient safety incidents, feedback from patients and staff, concerns, complaints, and claims. While we acknowledge that the QuOG is a relatively new group, we did not see evidence of lessons learning/sharing from our review of the QuOG minutes. Failure to effectively capture, share and use lessons learned to improve the overarching quality management system	The QuOG will fulfil its remit to identify, monitor and share lessons learnt across the directorates, divisions and teams of the Trust as mandated within its terms of reference.	QSIC		April 2026 Update: ToR were agreed at QuOG on 25 March 26 and to be taken to BET on 14 April, BET approved the ToR on 14th April. The action is complete. February 2026 Update: ToR have been reviewed by the Quality Oversight Group in Q3 and rewritten and discussed at QuOG on 20 Jan 26. A few minor amendments are required following this discussion and to take back to QuOG in Feb 26 for approval. Once this is complete, the ToR will be taken to BET for final review and approval. Once the ToR is approved, all processes will be in place to ensure the QuOG fulfills it's expected remit. Action on track for the 30th April 2026 deadline. October 2025 Update: Position remains the same as per the August 2025 update. August 2025 Update: As detailed in Action Ref. 652, this action is intrinsically linked with review of the Quality Oversight Group ToRs and potential subgroups: 1. Discussions ongoing at QuOG to highlight key learning from Standards Self-Assessment undertaken by Directorates or Divisions, recorded within minutes. 2. Quality Oversight Dashboard Standard added as a Standard Agenda item - presented at QuOG with key learning from themes and trends identified from incidents and complaints, recorded within minutes. ...	Request Action is Clo	Medium	Green
656	Audit Wales	Review of the arrangements for setting and monitoring well-being objectives	N/A	Executive Direct...	31/03/2026	31/03/2026	R2: Resourcing objectives To inform the development of future IMTPs, the Trust should set out how it is considering the resourcing requirements and risks of delivering the well-being objectives over the medium-term.	We consider the resourcing requirements and risks as part of our integrated planning approach to the development of our IMTPs, and will continue to refine and strengthen our planning approach. In addition, Strategic Risks are assigned to an Executive lead to review associated action plans and provide assurance updates to the Executive Team, Board and Committees of the Board. We do not have plans to move delegated authority or restructure to align to priorities, however we will consider an annual mapping exercise of resources (£'s) against our strategic priorities for future IMTPs.	ACGC		March 2026 Update: Complete - Resource mapping exercise complete and included in IMTP January 2026 Update: On track for completion on time October 2025 Update: Resource mapping exercise built into 2026-29 financial planning work and will be included in the 2026-29 IMTP to be submitted in March 2026. This work will be undertaken across quarters 3 and 4 of 2025/26. August 2025: On track for completion on time.	Request Action is Clo	N/A - Audit Wales	Green
660	Internal Audit	Non-core Funding: Health Improvement	Reasonable assurance	National Directo...	01/04/2026	01/04/2026	Grant administrative burden The grant administration process is largely manual and is resource intensive. Key performance information data confirms that the grants team processed 290 claims across six major programmes during 2024/25, including 90 claims for National Exercise Referral Scheme (NERS). Each claim involves validation, coordination with programme leads, and submission to Accounts Payable. Our review of the Grants Administration Flowchart and Grants Finance Log identified multiple layers of approval, short deadlines, and reliance on a team of three business support staff responsible for processing claims and ensuring compliance across multiple programmes. Programmes like NERS and WNHWPS require extensive quarterly submissions and over 60 individual reports annually. This volume places a significant strain on the central team and increases the risk of delay or error. For example: • In Q4 of 2024/25, over 20 grant claims were processed manually. Highlight reports show that delays in claim validation directly impacted invoice payment timelines, with some outside the 30-day target. • Several 2025/26 claim forms and delivery plans remained outstanding as of July 2025, requiring repeated follow-up and coordination. The Health Improvement Directorate has made improvements to grant administration in recent years and ...	Work will be undertaken to review existing processes and identify opportunities in the short and medium term to streamline the grants administration process, building on the existing improvements. Engagement with Directors of Public Health has commenced and a proposal for consideration will be developed. Upon agreement of the proposal, a plan will be developed, and improvements will aim to be implemented by 01 April 2026 ready for the 2026/27 grants cycle where appropriate.	ACGC	Chris Orr	March 2026 Update: Options and report are not finalised. Delayed due to capacity and competing priorities. Extent to what can be changed also impacted by election and discussions with WG. Looking to implement internal changes to further improve currrnt adminstration process during first half of 2026/27. New completion date of 30 June 2026. January 2026 Update: On track. Paper under development. Likley that any chnages will need further consideration in light of Public Health Wales allocation and consideration given to what can be implemented ahead or pending the outcome of the election. RAG: GREEN October 2025 Update: On track. Work has commenced and an options paper will be developed for consideration by the Health and Wellneing DLT in December 2025.	Request Change of D	Medium	Red
666	Internal Audit	Speaking Up Safely	Reasonable assurance	Board Secretary ...	31/03/2026	31/03/2026	Proportionate approach to directorate SUS champions While the Trust has two Board-level SUS champions, there are no SUS champions at a local level within Trust directorates or departments. We acknowledge that directorates vary significantly in size and function, with some comprising fewer than 50 staff and others, such as Health Protection and Screening Services, exceeding 1,400 staff. As such, a proportionate and dynamic approach to the implementation of local SUS champions may be more appropriate than a uniform model. This would support the broader cultural embedding of the SUS agenda and provide accessible points of contact for staff across different operational contexts.	The Trust should consider implementing a proportionate model for local SUS champions, tailored to the size, structure, and operational needs of each directorate. We will consider appropriate individuals who could support staff to speak up, such as staff side representatives, People and OD colleagues, Staff Diversity Network Chairs, and directorate representation. Champions should receive appropriate training and be supported by a network or oversight mechanism to ensure consistency and effectiveness.	PODC		April 2026 Update: This work remains ongoing. Following initial scoping discussions, a detailed proposal for the SUS Champions programme is now being developed. The organisation is currently being engaged to co design the proposed approach, including the scope, purpose and delivery model of the programme. A paper setting out the proposed direction will be presented to the Leadership Team meeting on 23 April for discussion. Subject to Leadership Team feedback, further structured engagement will take place with Trade Unions / Local Partnership Forum, Staff Networks, Business and Planning Leads, and the Business Executive Team (BET) to ensure appropriate consultation, alignment and organisational buy in. An extension to 30 September is requested to enable full implementation of the agreed approach. This will allow sufficient time to complete wider consultation and engagement, develop supporting resources (including training materials and role descriptions), and determine the appropriate scale and structure of the SUS Champions network, should this option be approved. The extension is therefore necessary to ensure that the approach is fully informed, appropriately resourced and implemented in a sustainable and effective manner. February 2026 Update: On track to be completed, the following are in development: - SUS Champion role descriptions - Development of a Training session set up to run through the process of SUS, to be delivered once we have the Champions list established. - Review of training / support materials already on the SUS Intranet pages to identify any gaps Discussion with LT planned for March on the approach ...	Request Change of D	Medium	Red
667	Internal Audit	Speaking Up Safely	Reasonable assurance	Board Secretary ...	31/03/2026	31/03/2026	SUS Training The Trust does not offer a dedicated training module aligned with the Welsh Government's Speaking Up Safely (SUS) framework (September 2023). While ESR includes SUS-related modules (e.g. Speak Up, Listen Up, Follow Up), these were developed by NHS England in 2020 and do not reflect the updated Welsh context. The Head of People and OD Operations has confirmed that discussions are ongoing between NHS Wales Shared Service Partnership (NWSSP) and Welsh Government regarding the development of a new e-learning package. In the interim, the Trust must determine whether existing ESR modules are suitable as recommended learning or whether alternative provision is needed to support consistent understanding and cultural embedding of SUS principles.	The Trust will assess the relevance of current ESR SUS modules in the context of the Welsh Government framework. Based on this review, it will determine whether to: • Endorse existing modules as interim learning. • Supplement with internal guidance or briefings; or • Await the release of the updated national e-learning package. • Consider internal comms strategy and other comms tools to enhance training. This will ensure staff receive appropriate and consistent messaging on SUS expectations and processes.	PODC	Paul Veysey	April 2026 Update: The SUS Leads have agreed to implement the approach outlined in the February update, and will be taking this forward in conjunction with the SUS Champions work once that is established. Propose the action is closed on that basis. Further work will be ongoing to update and refine the offer of training as the SUS process develops and updates will be reported to PODC in line with the assurance cycle. February 2026 Update: Discussion with the SUS leads on how to take this forward. The module is not suitable as it's the English model and doesn't reference SUS / WG context, therefore it is not suitable to endorse as interim learning. Agreed approach: - Review the learning that we develop for the SUS Champions - Consider other methods of disseminating and raising awareness. Consider developing our own training / video and include in the induction pack. - Messaging will be picked up as part of the communications plan - Consider how we share HEIW training already available. RAG Rating - GREEN October 2025 Update: This is on track - Green RAG rating for completion.	Request Action is Clo	Medium	Green
668	Internal Audit	Speaking Up Safely	Reasonable assurance	Board Secretary ...	31/03/2026	31/03/2026	Early stage development of SUS data and insight Six SUS concerns have been formally recorded since the Protocol's launch in February 2024, which may reflect the early stage of the SUS agenda within the Trust, and the emerging nature of data collection and reporting processes. The Welsh Government Framework encourages organisations to embed speaking up as a cultural gateway for all types of concerns. As the Trust continues to develop its approach, there is an opportunity to strengthen the capture and analysis of SUS-related data to support learning, identify trends, and provide assurance to the Board. From a policy design perspective, SUS is appropriately referenced across Trust documentation. However, the supporting data infrastructure and reporting mechanisms are still maturing, which may limit the ability to fully demonstrate cultural embedding and organisational learning at this stage	The Trust will continue to develop its SUS data collection and reporting mechanisms, with a view to enhancing the quality and consistency of information captured. Consideration will be given to establishing a framework for analysing SUS concerns over time, including mechanisms for identifying themes, tracking outcomes, and capturing lessons learned. Establish a quarterly review meeting with SUS leads to review outcomes and learning. This group will review learning and future developments and as the SUS agenda matures, the group will also explore opportunities to integrate SUS data into broader Trust learning and assurance processes.	PODC	Paul Veysey	April 2026 Update: This has been completed. The SUS Leads now meet at least quarterly and are reviewing the data on an ongoing basis. We are moving documentation over to SharePoint which will assist with extracting data for reporting and have a mechanism for capturing learning. Propose the action be closed on that basis. Further work will continue in year to develop the level of reporting for next years Annual report. January 2026 Update: This is on track. RAG rating GREEN. October 2025 Update: This is on track - Green RAG rating for completion.	Request Action is Clo	Medium	Green

669	Audit Wales	Improving Quality Governance	N/A	Board Secretary ...	31/01/2026	26/03/2026	The Trust should introduce a systematic, Trust-wide approach for proactively testing awareness of, and compliance with quality governance policies.	Review the PHW Policy for Policies, Procedures and other written control documents to ensure the requirement for policy owners to routinely audit / test compliance and awareness for all Policies. Amend the Policy approval cover sheet to include more explicit requirement to test awareness as part of the implementation plan.	ACGC	Liz Blayney	April 2026 Update: The Policy has been reviewed and updated, the finalisation of this has been put on hold pending recruitment to appoint a Policy lead within the Board Business Unit to take this work forward as additional resources are required to fulfil this effectively. Further changes to the process may be implemented following feedback from the organisation and work ongoing relating to decision making may also have an impact on this policy. As such we have put this work on hold until the post holder is in place and the Decision making work has concluded to avoid duplication. Request extension to 31 July 2026. January 2026 Update: Review is ongoing, request extension to 26 March 2026 (Board Date) to allow for a more extensive consultation, and to allow the outcome and discussions following a deep dive with the Leadership Team on the Policy process to be incorporated into the Policy. This was suggested at the Leadership Team meeting in December and will take place in February. Requested extension aligns with the Board date in March for final approval. RAG Rating – RED. October 2025 Update: This is on track - Green RAG rating for completion. The Policy is currently being reviewed within the Board Business Unit, as part of a wider review of this policy. It is scheduled on the Board forward look for approval in January 2026, and will go to consultation in December 2025. No risks identified to completion of this action at this stage.	Request Change of D	N/A - Audit Wales	Red
670	Audit Wales	Improving Quality Governance	N/A	Nursing, Quality...	30/04/2026	30/06/2026	The Trust should introduce a systematic, Trust-wide approach for proactively testing awareness of, and compliance with quality governance policies.	Developing a schedule for auditing each Quality Governance Policy, and results to be included in the Audit Section of the quarterly Quality Governance report to QSIC. Summarise any audit activity relating to Quality Governance Policies in the end of year report Q4 report or the Annual Reports for each area.	ACGC		April 2026 Update: Work ongoing to determine and highlight relevant quality governance policies. BBU updating overarching policy on Policies, Procedures and Other Written Control Documents which needs to include an explicit requirement for policy owners to routinely audit / test compliance and awareness. The current deadline for this action will unlikely be met, and so an extension of 30th June 2026 is requested. Rag rating is Red due to current deadline unlikely to be met. February 2026 Update: There are audits scheduled in the 2026-27 plan that relate to quality governance policies e.g. Consent, Best Interest Decision Making and Decontamination. The work to develop a systematic schedule for auditing all PHW Quality Governance Policies has been on hold due to a delay on the revision of the policy on Policies, Procedures and Other Written Control Documents which needs to include an explicit requirement for policy owners to routinely audit / test compliance and awareness. The current deadline for this action will unlikely be met, and so an extension of 30th June 2026 is requested. Rag rating is Red due to current deadline unlikely to be met. October 2025 Update: On track and will be included in the audit plan for 2026-27.	Request Change of D	N/A - Audit Wales	Red
671	Audit Wales	Improving Quality Governance	N/A	Nursing, Quality...	31/03/2026	30/04/2026	The Trust should more explicitly and transparently report the changes it has made in response to service user feedback. This should include reports to QSIC, and more explicit use of "You Said, We Did" to support reporting on its website of service changes stemming from service user feedback.	The Implementation plan for the People's Experience Framework is being discussed and developed on 1st October at the internal People Experience Group (Service user group). This plan includes the introduction of 'You said we did' display within PHW managed public facing sites with quarterly information displayed.	ACGC		April 2026 Update: The PHW Experience Standards were tabled and endorsed at the March Quality Assurance Oversight Group. An executive paper is being drafted to recommend the approach, along with an implementation outline and timeframe. You Said We Did is one of the Standards within the document. Although the wider service aimed Standards implementation will start in full from 1 April 2027, certain Standards, such as You Said We Did, will be implemented well before (August 2026). Many of the Standards, such as You Said We Did, Wall of Thanks and Exp Dashboard, will be allocated to the Experience team and implemented during 2026. February 2026 Update: We have drafted a You Said We Did information page and shared this with the People's Exp Learning Group on 4 Feb 2026. The new page will be available on the public-facing internet pages, and with PHW moving to a new web software, we are undertaking training mid Feb 2026, which will help us create and update the information. The new PHW website is due to go live on 26 March 2026. This action is on track for delivery by 30th April 2026, as per the current implementation target date. October 2025 Update: An action to develop an organisational 'You Said We Did' intranet page and poster template was agreed at the October 2025 People's Experience Learning Group (PELG). Work is underway to develop templates in readiness for discussion at the January PELG meeting for further comments. The poster and intranet pages will be live by 31st March 2026. The above action has also been included within the draft Implementation plan for the People's Experience Framework. This plan is currently being developed and collaborative workshops planned for December 2025 and January 2026. The aim is for the implementation plan to be developed by 30th April 2026. Request an extension for this action to 30th April 2026 to enable broad engagement and buy in to the implementation plan.	Request Action is Cl	N/A - Audit Wales	Green
672	Audit Wales	Improving Quality Governance	N/A	Nursing, Quality...	31/05/2026	31/05/2026	The Trust should more explicitly and transparently report the changes it has made in response to service user feedback. This should include reports to QSIC, and more explicit use of "You Said, We Did" to support reporting on its website of service changes stemming from service user feedback.	As part of the 'Always on' Reporting working group a public facing website is being developed to include a 'you said we did' section which will detail changes made as a result of service user feedback.	ACGC		February 2026 Update: We have drafted a 'You Said, We Did' information page and shared this with the People's Experience Learning Group on 4th February 2026. The new page will be available on the public-facing internet pages and is due to go live on 26th March 2026. Action is on target for delivery by the 31st May due date. October 2025 Update: The actions from 671 feed into the 'Always on' reporting via the working group. This will include the 'You Said We Did' information being made available public. Awaiting results and analysis from recent 'Time to Talk' public survey which focused on 'Always on reporting' and the DoQ Annual Quality Report. The feedback will be considered and built into the solution. Action on track.	None - Action in Dat	N/A - Audit Wales	Green
673	Internal Audit	Workforce - Mental Health Support	Reasonable assurance	Director People ...	30/06/2026	30/06/2026	Managing Attendance at Work (MAAW) Staff training We tested a sample of mental health-related sickness absence episodes. We considered if line managers, who conducted the Return to Work (RTW) meetings, had completed the Managing Attendance at Work (MAAW) training. We note: • 9/14 responders were either unaware of the training or had not undertaken the training. • 4/14 line managers had not undertaken MAAW training in the last 3 years, which is longer than the recommended time. • No response was received from six line managers within the sample. People and OD recommend that MAAW training is completed every three years. While we understand that a refresher course is recommended, it is not mandatory. The team is awaiting the release of an e-learning module for MAAW, which will become a mandatory requirement for line managers.	Management will ensure the delivery of learning and development on the Managing Attendance at Work (MAAW) Policy for individuals with line management responsibilities. Once the e-learning is available, the MAAW course will be incorporated into the organisation's induction guidance, as well as updated within relevant policies and procedures (noted that the Policy and e-learning are both developed and agreed at an All-Wales level).	PODC	Jenny Ansell (POD Operations Service Manager)	March 2026 Update: The e-learning module that was shared with PHW was for quality assurance checking. This has now been done and was returned to NWSSP in February. We are currently awaiting confirmation of a go-live date. POD continue to deliver the MAAW training internally. RAG = Amber (potential delays due to release of the module not yet confirmed. POD will continue to deliver until e-learning module is available) January 2026 Update: We have now received the MAAW e-learning module. The next steps will be to identify in ESR all those with line management responsibility and to allocate the module to them for completion. Plan to complete this by the end of April	None - Action in Dat	Medium	Amber
674	Internal Audit	Workforce - Mental Health Support	Reasonable assurance	Director People ...	30/06/2026	30/06/2026	We reviewed a sample of 20 mental health-related sickness absence episodes which identified gaps in compliance with the Managing Attendance at Work policy: • Late recording: Four sickness episodes were entered on ESR between 23 and 140 days after absence began. • Missing or incomplete documentation: Two samples lacked supporting documents; five self-certification forms were missing or incomplete; one case had no RTW or self-certification forms. • Form Errors: Discrepancies between ESR and RTW/self-certification dates; unsigned or undated forms; one RTW form had an incorrect historical sign-off date. • GP Fitness Notes: Four samples missing notes; one sample had three notes without the staff member's name.	Management will ensure line managers undertake the MAAW training and strengthen compliance with the application of the MAAW policy by ensuring: • Communication to managers on the importance of appropriate certification for sickness absences. • Timely recording of sickness absence episodes on ESR. • RTW interviews conducted promptly. • Adequate completion and storage of related documentation. • Provision of regular training and refresher sessions for line managers.	PODC	Jenny Ansell (POD Operations Service Manager)	March 2026: Comms has been shared with the Communciation team and is planned to go out in the Managers News in April. RAG = Green January 2026 Update: Plan to include regular reminders in Managers News. Managers will be required to renew the MAAW e-learning module every three years	None - Action in Dat	Medium	Green
676	Internal Audit	Corporate Risk Register Effectiveness	Reasonable assurance	Nursing, Quality...	31/07/2026	31/07/2026	Risk Appetite Framework The risk appetite framework will enable the effective application of risk appetite across the wider risk management process, but it is yet to be fully implemented. Risk appetite definitions contained within the risk appetite statement are brief where additional detail would be useful, and there is a minor error in the first category header.	The Risk Appetite Framework will be finalised, approved and implemented. Risk appetite definitions contained within the Risk Appetite Statement will be updated to include additional detail.	QSIC	Danielle Gething – Head of Risk Management	March 2026 Update: No further progress made due to competing priorities and limited resource. February 2026 Update: Operational Risk Appetite had been due to be signed off at the Risk Assurance Network in November 2025 after tasking members to consider the proposal in their areas. This was postponed due to the priority of carrying out a user centred design workshop with members in relation to the risk management replacement system. No comments or feedback have been received from members since they were tasked with carrying out engagement in their areas of the proposal, as such at the next Network meeting, it is being tabled for approval and schedule arranged for implementation. This action is on track to be delivered by the 31st July 2026 deadline.	None - Action in Dat	Medium	Green

677	Internal Audit	Corporate Risk Register Effectiveness	Reasonable assurance	Nursing, Quality...	31/03/2026	31/03/2026	Training compliance Although a programme of standardised and bespoke training activities has been maintained, the compliance rates are low, principally due to the large numbers of potential attendees that have been identified. The Datix permissions list has not been subject to a recent review.	Training activities will continue and the recorded sessions will be used to reach a wider audience. The Datix permissions list will be reviewed.	QSIC	Beth Osborne – Risk Manager	March 2026 Update: The spreadsheet has been fully updated and process put in place to maintain it going forward, therefore this element of the action is completed. Request Action is closed. February 2026 Update: Meeting arranged with Datix Technical Support Officer and Risk Manager on 06/01/2026 to agree process for completing this action. As advised during the internal audit interviews, this spreadsheet is not used by PHW to establish accurate training figures (as it only lists handlers/owner) as such a new process will be implemented to satisfy this recommendation. Action is on target to be delivered by the 31st March 2026 due date.	Request Action is Cl	Medium	Green
678	Internal Audit	Digital Audit Logging	Reasonable assurance	National Directo...	30/06/2026	30/06/2026	Logging Procedure There is no formal procedure or statement covering the organisation's approach to logging of user activity within digital systems.	A local procedure will be developed to define the approach for logging user activity. This procedure will complement the broader Public Health Wales policy on system and security logging.	ACGC	Dafydd James		None - Action in Dat	High	
679	Internal Audit	Digital Audit Logging	Reasonable assurance	National Directo...	30/06/2026	30/06/2026	Logging Approach Logging activity is the default for the 'system on' set up and so is inconsistent and there is no formal onboarding process that ensures the logging needs for new applications are formally assessed. In addition, there is no consideration of critical data fields within applications to ensure that activity over those is purposefully recorded to enable protection of the data.	Although server-level 'system-on' logs are already generated, further monitoring and recording of user activity within applications is also in place. The assessment of logging requirements, including identification of critical activities that require enhanced oversight, will be incorporated into the new logging procedure.	ACGC	Dafydd James		None - Action in Dat	Medium	
680	Internal Audit	Digital Audit Logging	Reasonable assurance	National Directo...	30/06/2026	30/06/2026	Log Management Changes to the logs can be made by the administrator as the files are not tamper resistant and there is no monitoring process to identify gaps in logs. We also note that the lack of a formal statement over logging means that there is no formal process to set log sizes and ensure logs are not	Digital Services will review the tamper-resistant controls that can be applied or implemented across digital systems to strengthen integrity of log data. Some controls—particularly those linked to privileged Role-Based Access Control (RBAC)—are already in effect. Requirements for log sizes, storage, and retention periods will be defined	ACGC	Dafydd James		None - Action in Dat	High	

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