Bundle BCU Audit Committee 16 December 2025

1 SUPPORTING PAPERS

2 AC25.167 Appendices 2 to 6 Supporting papers for Internal Audit report

AC25.167c App2 IAR BCU_2526_11 Final Internal Audit Report Learning Regulatory Reporting

AC25.167d App4 IAR Final Complaints Management

AC25.167e App3 IAR BCU2526-15 Del change and benefits final IA report

AC25.167f App5 IAR BCU-2526-17 Final Internal Audit Report Community Services for client issue

AC25.167g App6 IAR BCU-2526-38 Final Internal Audit report Corporate Directors procurement

Learning – Regulatory Reporting

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-11
Fieldwork	June - September 2025
Executive Sign Off	1 November 2025
Audit Committee	December 2025
Executive Lead	Pam Wenger, Director of Corporate Governance
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the effectiveness of established processes and governance arrangements for the management and implementations of learning from regulatory reports. Limitation - note that we have not undertaken any testing on the evidence supporting Learning from Events Reports (LFERs) as these are subject to review by the Welsh Risk Pool.

Overview

We have concluded limited assurance on this area. The matters requiring management attention include:

- There is no policy or overarching written control documents (SOP, guidance notes etc) in place to support operational processes and ensure regulatory engagement, implementation, compliance, and escalation are managed consistently.
- The Health Board does not retain a central register of regulatory reporting routes, engagement, and key contacts. Due to low engagement, we were only able to establish the key Health Board contacts for ten of the twenty-two known regulators – The limited engagement to our request for evidence and information does not meet the requirement set out in Standing Financial Instruction 3.2.2.
- The Health Board Regulatory Assurance Group is not fulfilling its remit per the Group terms of reference – the Group's oversight is restricted to a limited number of regulators / regulatory reports (Healthcare Inspectorate Wales, Care Inspectorate Wales, Public Service Ombudsman for Wales, and Health and Safety Executive).
- For the ten regulators reviewed, we confirmed that processes have been established to manage and implement improvement actions and report recommendations to ensure compliance with regulatory requirements. However, processes, reporting, and oversight arrangements vary by regulator, area, and / or service and there is no consistent escalation route from local forums to Board or relevant Committee. We cannot confirm that the Board receive comprehensive assurance regarding regulatory compliance.
- There are no formal processes or requirements regarding the management, extraction, sharing, implementation, and tracking of wider learning from regulatory reports. Whilst examples of wider learning being shared were provided we cannot be assured that this is consistent for all regulatory reports, or that required actions from the shared learning are implemented.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

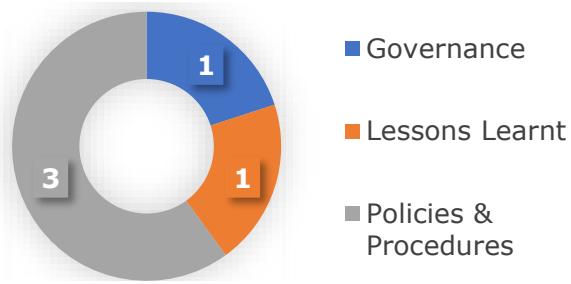
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	1, 2, 3	**Limited**
2	There is evidence to demonstrate that opportunities for learning from regulatory reports are implemented, and outcomes are reviewed to ensure effectiveness and limit future occurrence.	4, 5	**Limited**

Management Actions

5	0
High Priority	Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	**Limited**

We determined at the outset of the review that the Health Board is subject to the remit of approximately twenty-two (22) Statutory Regulators / Inspectorates and Professional Clinical Regulators, ten (10) standards setting and oversight bodies, and twenty-eight (28) Royal Colleges and Societies / Facilities (this number may not be exhaustive).

To manage and oversee regulatory assurance, the Health Board have established the Regulatory Assurance Group (RAG), a formal sub-group of the Executive Delivery Group for Quality. The RAG terms of reference states that the group, *"is the single point of focus for all healthcare related regulation oversight and assurance activity across the Health Board and will seek assurance on progress and ensure actions are delivered in a timely fashion".* However, the group currently only receives updates for a limited number of regulators, namely Healthcare Inspectorate Wales (HIW), Care Inspectorate Wales (CIW), Public Service Ombudsman for Wales (PSOW - though not a regulator), and recently the Health and Safety Executive (HSE). We do note that the regulatory reports reviewed by RAG are subject to robust oversight and scrutiny by the Group.

The Health Board does not retain a central register of regulator engagement routes, reporting lines, or relevant Health Board contacts, and there are no overarching formal written control documents (policy, standard operating procedures) outlining the requirements and expectations for managing, delivering, and engaging with regulatory bodies. We contacted Area / Service Directors and Senior Managers to request details of the regulators they engage with and key contacts to support our review. However, due to the level of engagement we were only able to establish the operational processes for ten of the twenty-two known regulatory bodies (and two oversight bodies – PSOW and Network and Information Systems (NIS)).

The form and content of regulator reports and notifications vary significantly, from improvement notices and general reports to the outcome of Health Board specific reviews, compliance, and inspection audits. In most cases the notifications / reports specify necessary improvement actions to meet regulatory requirements – they do not outline wider learning. All respondents detailed the operational processes established to support and manage the delivery and implementation of recommendations and required improvements, including the use of action trackers, evidence-based closure, and oversight forums; however there is no formal mechanism in place to track and manage the extraction and sharing of wider learning from regulatory reports.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance** We reviewed the governance arrangements in place and noted the following limitations: • The Health Board does not have an overarching policy or written control documents in place to support operational processes and ensure regulatory engagement,	Lack of guidance for staff and robust governance arrangements leading to uncertainty re reporting, ownership,	**Agreed Action:** • An overarching policy and associated written control document will be approved to support operational processes and ensure regulatory engagement, implementation and compliance, ensuring escalation is managed consistently. • A central register of regulators as well as Executive Team Member lead, and regulatory reporting routes

	implementation, compliance, and escalation are managed consistently. • The Health Board does not retain a central register of regulatory reporting routes. Due to low engagement, we were only able to establish the key Health Board contacts for ten of the twenty-two known regulators • Areas / services have developed processes to manage regulatory reports and engagement independently – there is no consistent escalation route from local forums to Board or relevant Committee.	escalation, and accountability. The Board does not receive assurance of regulatory compliance.	• The Corporate Governance Directorate to work with areas/services to develop processes to manage regulatory reports and engagement independently. **Expected Evidence of Implementation:** • Robust policy / SOP in place to support operational processes - defined requirements and expectations. • Health Board to map all regulatory engagement to ensure all regulators and engagement routes are captured. • Consistent requirements re oversight, reporting, and escalation - would expect all regulatory reports / notices to be subject to RAG oversight and scrutiny.
		High Priority	**Officer: Head of Statutory Compliance and Inquiries** **Target Implementation Date: 31st March 2027**
	Theme: Policies & Procedures	Control Design	
2	**Regulatory Assurance Group (RAG)** The Health Board Regulatory Assurance Group is not fulfilling its remit per the Group terms of reference as "*the single point of focus for healthcare related regulation oversight and assurance activity across the Health Board*" – the Group's oversight is restricted to a limited number of regulators / regulatory reports (HIW, CIW, PSOW, and HSE). Note that the regulatory reports reviewed by RAG are subject to robust oversight and scrutiny by the Group.	Inconsistent oversight and lack of transparency of regulatory activity across the Health Board. No single point of assurance and therefore unable to provide assurance to the Board on regulatory matters.	**Agreed Action:** The Health Board has existing arrangements in place and the spirit in which the Regulatory Assurance Group was established was to focus on the Regulators as defined in the Duty of Quality. Therefore to avoid any confusion, it is recommended that the Terms of Reference are reviewed. • Review the Terms of Reference to reflect the role of the Group in line with the Quality Regulation Policy (Head of Quality) • To develop a corporate procedure and reporting routes for the monitoring of regulatory reports at a corporate level; eg, MHRA, HSE and other regulators (Head of Statutory Compliance and Inquiries) **Expected Evidence of Implementation:** • RAG to receive regular updates for all Health Board regulatory reports / notices. • Evidence of scrutiny by RAG. • Evidence of assurance provided to the BCU Board or its Committees.
		High Priority	

	Theme: Governance	Control Operation	**Officer: Head of Quality and Head of Statutory Compliance and Inquiries** **Target Implementation Date: 31st March 2026**
3	**Operational Processes** For the ten regulators reviewed, we confirmed that processes have been established locally to manage and implement required improvement actions to ensure compliance with regulatory requirements. However, we noted the following limitations: • Regulatory reports are not managed consistently across the Health Board - processes, reporting, and escalation arrangements vary by regulator, area, and / or service. • There are no formal processes or requirements to support the management, sharing, implementation, and tracking of wider learning from regulatory reports. • We were unable to verify the robustness and consistency of oversight and escalation arrangements from the evidence provided and could not confirm that regulatory assurance is consistently provided to the Board.	Inconsistent working practices, lack of guidance and robust oversight and escalation arrangements, resulting in possible breaches of regulatory requirements, and an adverse impact on patient / staff safety.	**Agreed Action:** • A consistent process will be implemented to manage regulatory reports to include reporting and escalation arrangements by regulator to ensure robustness and consistency of oversight and escalation arrangements • High level reporting against regulatory reports will be included in the statutory compliance report to Audit Committee as well as individual oversight by committees as per the Scheme of Delegation. **Expected Evidence of Implementation:** • Regulatory reports are managed consistently across all services / areas for all regulators. • Expectations and requirements re extraction, management, sharing, and implementation of wider learning from regulatory reports are clearly defined. • Defined escalation routes from local operational forums to Board / Committee.
		High Priority	**Officer: Head of Statutory Compliance and Inquiries** **Target Implementation Date: 31st March 2027**
	Theme: Policies & Procedures	Control Design	

Objective 2: There is evidence to demonstrate that opportunities for learning from regulatory reports are implemented, and outcomes are reviewed to ensure effectiveness and limit future occurrence.	**Limited**

As previously noted, there are no formal processes, mechanisms, or overarching written control documents in place to support the management, extraction, sharing, tracking, and implementation of learning from regulatory reports. Areas have developed operational practices independently, focusing on the delivery and implementation of necessary improvement actions or recommendations to meet regulatory requirements. Despite this, several of the responsible officers advised that wider learning, where applicable, is extracted from the regulatory reports and shared via relevant forums, though this is not formally tracked.

The following examples were provided:

- Wider sharing of the findings and requirements of the recent ligature related Health and Safety Executive improvement notices.

- Water boiler fire leading to the manufacturer undertaking a Health Board wide review of all supplied boilers and initiating remedial work where needed.
- Learning from the 2023 Luton Airport muti-storey car park fire led to the review and assessment of parking in the East acute and community sites, findings of which were shared at the IHC East Health, Safety and Risk Meeting.
- Health Board wide implementation and roll out of offensive waste stream following Natural Resource Wales's review of Ysbyty Glan Clwyd.

We noted that examples of the Organisational Learning Forum Monthly Highlight Report templates were submitted as evidence to demonstrate the reporting and sharing of learning. However the reports provided were incomplete, and no further information or context regarding the role or remit of the Organisational Learning Forum was provided for review (the examples given were completed submissions for the Nursing and Midwifery Council (NMC) and Public Service Ombudsman for Wales (PSOW)).

Key Findings		Risk & Impact	Agreed Management Action
4	**Learning (Process)** There is no policy or other formal written control documents in place outlining the requirements regarding the extraction, management, sharing and tracking of learning from regulatory reports. Regulatory reports and notices do not typically specify wider learning - they provide defined improvement actions needed to meet regulatory standards. Despite this, examples of wider learning being extracted and shared were provided for review. However, we cannot be assured that this is consistent for all regulatory reports, or that all opportunities for learning are captured.	Inconsistent operational processes and management leading to failure to identify and share learning from regulatory reports, which may have an adverse impact on patient / staff safety.	The Executive Committee has established a Learning and Discovery Group which will focus on the learning from external reports and inquiries, this will ensure that learning is extracted implemented in the Health Board **Agreed Action:** • Develop Standard Operating Procedure outlining how learning is to be extracted, shared, tracked, and implemented. **Expected Evidence of Implementation:** • Requirements re the extraction, management, sharing, tracking, and implementation of learning from regulatory reports are clearly defined - via policy / SOP etc. • Controls in place to monitor compliance and ensure all opportunities for learning are captured, shared, and implemented / actioned.
		High Priority	**Officer: Head of Statutory Compliance and Inquiries** **Target Implementation Date: March 2026**
	Theme: Policies & Procedures	Control Design	

5	**Implementation and tracking of learning** The Health Board does not have a formal system to track the implementation and impact / outcome of shared learning from regulatory reports. For the examples provided, we were able to confirm that the relevant learning had been shared, however could not confirm in all cases that required actions were subsequently implemented / actioned.	Failure to implement learning resulting in breaches of regulatory requirements, which may have an adverse impact on patient / staff safety.	The finding in this recommendation is linked to the key finding in 1 and this is already included in the work programme as described in the IMTP. The action will therefore be aligned to the Board approval of the IMTP. Agreed Action: • Develop and implement a formal system to track the implementation and impact of shared learning from regulatory reports across the Health Board. **Expected Evidence of Implementation:** • Established system to formally track the impact / outcome of shared learning from regulatory reports.
		High Priority	**Officer: Head of Statutory Compliance and Inquiries** **Target Implementation Date: March 2027**
	Theme: Lessons Learnt	Control Design	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **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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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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

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

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Complaints management

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2526-13
Fieldwork	August - October 2025
Executive Sign Off	November 2025
Audit Committee	December 2025
Executive Lead	Angela Wood, Executive Director of Nursing and Midwifery
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Patrick Williams, Principal Auditor

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Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership

Audit and Assurance Services

Executive Summary

Purpose

To review compliance with the Integrated Concerns Policy published in 2024.

We have only reviewed elements of the policy relating to complaints management.

Overview

There has been significant improvement in closing complaints received within 30 working days since the Health Board was placed into Special Measures[1]; We recognise the introduction of an oversight structure focusing on compliance with the *NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* and its own policy.

We have concluded reasonable assurance, with the following matters requiring management attention:

- Holding letters are not consistently issued prior to the 30-day response deadline being exceeded – Not compliant with Regulation 26 (3), *The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*.
- There was no supporting evidence within DATIX to verify that actions outlined in the Learning and Improvement Plan, as part of investigation reports, had been completed and closed by the relevant operational areas.
- Audits are not currently being conducted to verify that evidence is uploaded to substantiate the completion of actions.
- Focused complaints training is being delivered on an ad hoc/request basis and supplements that set out in Policy; no records are retained of who attended the training delivered by the Complaints Team.
- Recurring themes and trends highlighted in reports to the Health Board have remained largely unchanged, suggesting that learning from the complaints are not being embedded at an operational level, despite the corporate support provided by the Complaints Team.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Certain aspects of the Integrated Concerns Policy, particularly those relating to timelines and training, implied relevance to the complaints process; On discussion with officers, we were advised they apply only to the incidents process – Management may wish to consider presentational changes to the policy to limit any ambiguity concerning timelines and to which process they apply.

[1] *'During 2022 to 2023, 29.4% of complaints were closed within 30 days, compared to the all-Wales target of 75%. In March 2023, there were 290 overdue complaints, demonstrating a significant backlog and a missed opportunity to respond to the public in a timely and candid manner, and to learn and improve in real time. Complaints resolution has shown steady improvement. In October 2024, the health board achieved the 75% target, which has been maintained.'* **Source: Welsh Government, 4 March 2025; https://www.gov.wales/betsi-cadwaladr-university-health-board-special-measures-level-5-year-2-progress-report-html**

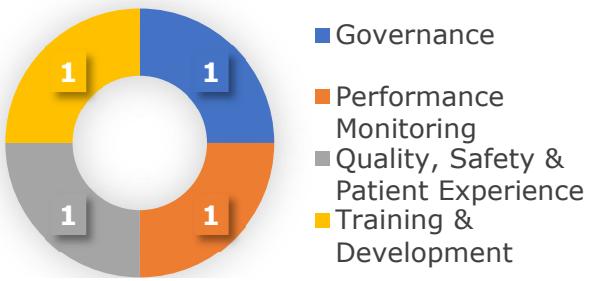
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is appropriate guidance and training for staff in relation to handling and investigating complaints.	1	**Substantial**
2	Complaints have followed the relevant process and are supported by documentation and evidence i.e. investigation reports, learning.	2,3	**Limited**
3	There is effective oversight and reporting of complaints within the Health Board, including themes/trends and performance of areas across the Health Board, such as compliance with published timescales.	4	**Reasonable**

Management Actions

3	1
High Priority	Medium Priority

Themes

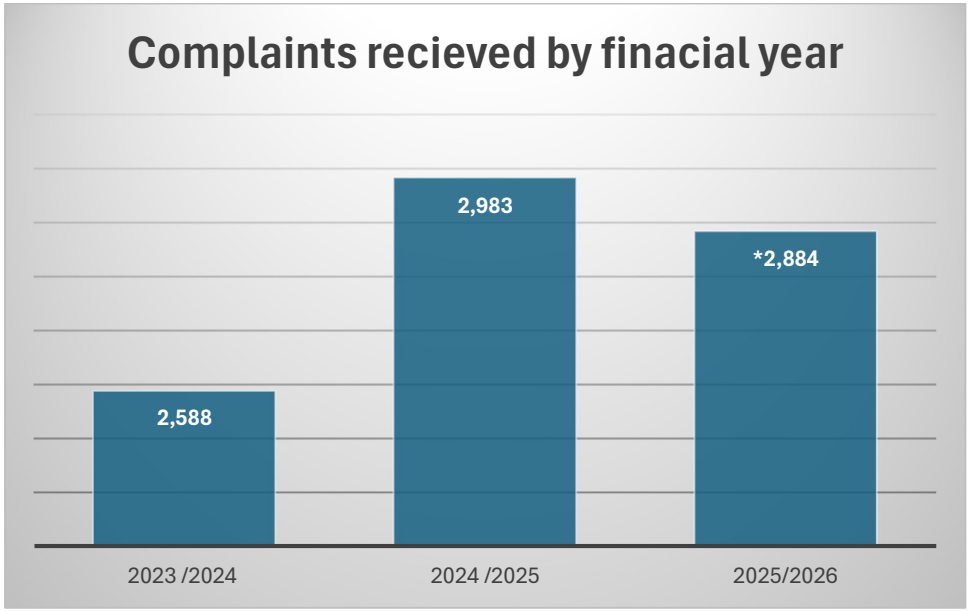


Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

At a Glance: Complaints received by the Health Board with Themes (Subjects) of complaints received



Top 6 Subjects for *ALL* Complaints Received				
Subject	2023/2024 Rank	2024/2025 Rank	2025/2026 Rank	cf
Clinical treatment/Assessment	1st	1st	1st	↔
Communication Issues (including Language)	2nd	2nd	2nd	↔
Attitude and Behaviour	3rd	3rd	5th	↓
Medication	4th	4th	3rd	↑
Appointments	5th	5th	6th	↓
Patient Care	6th	6th	4th	↑

*2025/2026 data is estimated for comparison purposes based on figures held by the Health Board for the period 1 April and 30 September 2025 inclusive; the estimated 2025/26 figure suggests a 3% decline in complaints when compared to 2024/2025.

Source: Head of Patient Experience - Please note that we have not corroborated the data provided.

Findings & Agreed Action Plan

Objective 1: There is appropriate guidance and training for staff in relation to handling and investigating complaints.	Substantial

There are several guides available for staff on the intranet (BetsiNet portal) to provide support to staff.

The Health Board's public facing internet site: Support, Concerns and Complaints: Who to Contact - Betsi Cadwaladr University Health Board (external link) provides guidance on how to submit a complaint. The page also signposts the reader to Putting Things Right, Duty of Candour and Public Services Ombudsman for Wales web sites.

Training in accordance with Section 5.2 of the Integrated Concerns Policy is led by the Patient Safety Team, with the Complaints Team offering supplementary support.

Three available courses delivered by the Complaints Team focus on Complaints Training; Early Resolutions; and Complaint Investigation Training.

During our review we were unable to confirm attendees at the complaints specific training as no training records are maintained. We also found that the training prospectus for complaints is not included on the Concerns Portal (BetsiNet site) and noted complaints training is not a required training programme for staff to undertake, although we recognise it may only apply to certain management tiers.

Key Findings		Risk & Impact	Agreed Management Action
1	**Training** Although complaints training is being delivered on an ad hoc/request basis and supplements that set out in Health Board Policy, no records are being kept by the complaints team. The training prospectus is not advertised on Intranet enabling staff to book on complaints specific training.	Unable to identify skill gaps undermining effective performance management and ongoing improvement initiatives.	**Agreed Action:** A formal training programme for the new Listening to people framework is currently in developed, which will be systematically rolled out across the health board, including access through Betsi net of e learning. A log of attendance will be monitored, and reported on for areas of low attendance.
			Expected Evidence of Implementation: Training records kept, prospectus added to the intranet and consideration given how the delivery of complaints training could be facilitated to the implementation of mandatory complaints training as part of staff development.
		Medium Priority	**Officer:** Head Of Patient Experience/ Lead Complaints Manager
	Theme: Training & Development	Control Operation	**Target Implementation Date:** 1 April 2026

Objective 2: Complaints have followed the relevant process and are supported by documentation and evidence i.e. investigation reports, learning.	Limited

We reviewed a sample of twelve (12) complaints graded by the Health Board at levels 1 (No harm) to 3 (Moderate harm) and whilst overall the expected controls were achieved, our sample included that six exceeded the thirty (30) working day timeline, where a holding letter is needed to be issued per Regulation 26 (3) of *The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* (the Regulations). Of these, four (67%) did not comply with the Regulations as no holding letter had been issued.

We reviewed compliance with Learning and Improvement Plans for a sample of ten complaints graded level 4 (Severe harm) and level 5 (Catastrophic harm) and all had a Learning and Improvement Plan.

We reviewed whether evidence was uploaded into the DATIX reporting system to support closure of agreed action plans as well confirming that rolling audits are being undertaken by the Complaints Team – Both were not evident as being completed and are noted as a breach of Policy 16.7.

We sought evidence on reopened complaints and how they are reported. We were advised that the Complaints Team re-opens closed complaints and for the period 1 April to 30 August 2025, ninety-four (94) complaints (8.2%) were re-opened out of one thousand one hundred and thirty-eight (1,138) complaints, with thirty-eight (38) due to dissatisfaction with the initial response.

Key Findings		Risk & Impact	Agreed Management Action
2	**Holding letters** Our testing showed that holding letters are not always sent when complaint reviews exceed the 30-working-day regulatory timeline.	Failure to send holding letters will result in non-compliance with Statutory Regulation.	**Agreed Action:** A weekly action list (every Monday) is now drawn from Datix identifying holding letters to be sent which will be undertaking by the corporate complaints team to remedy the issue immediately. On the rollout of the new Listening to People framework, the roll of sending out holding letters will be led by services, due to ownership of the complaint aligned to new processes.
			Expected Evidence of Implementation: Ensure holding letters are sent to those complaints that are going to exceed the 30-day response deadline.
		High Priority	**Officer:** Head Of Patient Experience/ Lead Complaints Manager **Target Implementation Date:** 1 April, 2026
	Theme: Governance	Control Operation	
3	**Learning and Improvement Plan action plans – Compliance with Policy**	Learning lessons from complaints are not evidenced, leading to a risk	**Agreed Action:** PTR 01 Integrated Concerns Policy – paragraph 16.7 has been changed to ensure clearer wording that the learning from complaints must be evidenced and recorded by services.

	No supporting evidence was noted in our review of DATIX to confirm the closure of actions, despite these being recorded as complete and closed. We also confirmed that no routine audits are being undertaken by the Complaints Team to verify the closure of actions are supported – This is a breach of PTR 01 Integrated Concerns Policy – paragraph 16.7.	that the Health Board cannot demonstrate its commitment to continuous improvement, openness and transparency, potentially eroding trust in the complaints process.	In addition to this the health board is in the final stages of developing a dedicated learning repository to support evidence gathering on agreed learning actions identified in the complaints process. **Expected Evidence of Implementation:** Audits are regularly undertaken providing assurance that actions are being completed and are reported on for openness and transparency.
		High Priority	**Officer:** Head Of Patient Experience/ Lead Complaints Manager Target Implementation Date: 1 August 2026
	Theme: Performance Monitoring	Control Operation	

Objective 3: There is effective oversight and reporting of complaints within the Health Board, including themes/trends and performance of areas across the Health Board, such as compliance with published timescales.	**Reasonable**

Integrated Quality Reports have been regularly presented to the Health Board during its meetings in January; March; May; and July 2025. Additionally, we reviewed the papers from the Quality, Safety, and Experience Committee (QSE) meetings for December 2024; February; May and July 2025, all of which included an Integrated Quality Report. Each report presented included oversight in the following key areas.

- Number of complaints received per week by grade.
- Number of complaints received Vs Closed.
- Total number of complaints & Compliance.
- Compliance Breakdown by IHC / Service.
- Themes and sub-themes.

We note there are numerous other forums at an operational level that are meeting underpinning the reporting to Committee and Health Board.

We sought evidence learning from complaints has resulted in a positive outcome through a reduction in the theme, by which a complaint is classified. Our review identified the themes from complaints have remained principally the same for the last three years and despite consistent improvements in the turnaround times of complaints, the underlying issues appear to remain at operational directorate/departments where learning from complaints is not seeing a change by subject/theme.

Key Findings		Risk & Impact	Agreed Management Action
4	**Themes and Trends of Complaints** Our review has found that there has been no reduction in the themes of complaints despite a focus on turnaround times.	Failure to address root causes of recurring issues	**Agreed Action:** Approaching 50% of our complaints and patient experience enquires relate to clinical treatment and assessment and

Complaints should lead to action that resolves their underlying cause however we have not seen a reduction that reflects this by operational leads. The top five themes as classified by management are noted as: • Clinical treatment/Assessment. • Communication Issues (including Language). • Attitude and Behaviour. • Medication. • Appointments.	could hinder the Health Board's ability to deliver long-term improvements and meet strategic objectives.	principally waiting times, or suggested harm that has been caused by waiting times. We are anticipating this will remain the main theme for the foreseeable future given the wider system challenges facing health boards across the UK Focussing on themes and trends such as communication and attitudes and behaviours, these are within our gift of more focussed change and aligned to the BCUHB Core values. A thematic review will be undertaken on specific themes, which will provide insight and areas of poor performance, to which targeted improvement and support will be provided and evidence to be provided into the strategic patient and carer experience group (PCEG) and Organisational learning forum (OLF) to identify root causes
		Expected Evidence of Implementation: Ensure that ongoing monitoring activities are effectively verifying whether the actions taken are addressing the root causes of the issues.
Theme: Quality, Safety & Patient Experience	**High Priority** Control Operation	**Officer:** Head Of Patient Experience/ Lead Complaints Manager **Target Implementation Date:** 1 April 2026

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**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.

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

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

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Digital Benefits and Change

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2526-15
Fieldwork	August – September 2025
Executive Sign Off	14 October 2025
Audit Committee	December 2025
Executive Lead	Dylan Roberts, Chief Digital and Information Officer
Audit Team	Dave Harries, Head of Internal Audit
	Martyn Lewis, IT Audit Manager

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Executive Summary

Purpose

To review whether the Health Board has an appropriate framework and process in place to ensure business change is managed and that digital business cases are benefit focused and benefits are gained from investment in digital solutions.

Overview

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- Our testing noted that resourcing for benefits leads was not always included within business cases, both from the DDaT and the service perspective.
- Currently there is no structured process for reporting of benefits outside of individual projects and programmes.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and are highlighted for management information:

- Sharing the digital benefits framework on a wider basis across the Health Board may assist the culture change.

Scope & Assurance Summary

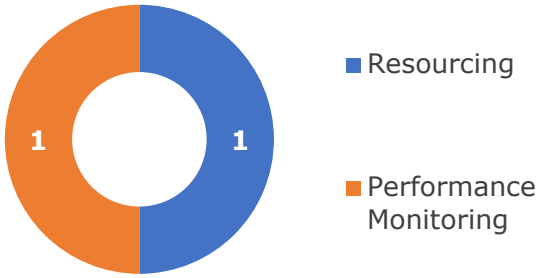
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	A framework for digital benefits realisation is in place which defines how benefits should be owned, identified, structured, planned and realised.	-	**Substantial**
2	Benefits focussed digital business cases show the value that project or programme will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baselined.	1	**Reasonable**
3	Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue.	2	**Limited**
4	Digital programmes include business change management activities, including the identification of required business change, revised ways of working, training and ongoing change management.	-	**Reasonable**

Management Actions

1 High Priority

1 Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: A framework for digital benefits realisation is in place which defines how benefits should be owned, identified, structured, planned and realised.	Substantial

Overview / Summary of Observations

Although benefits have always been considered within digital projects, the Health Board has taken steps to improve its digital benefits and change management in order to enable better delivery of digital services. A benefits lead has been appointed with the aim of the role being to provide oversight, guidance and monitoring of the benefits process.

Training on benefits has been provided to the lead, and to leaders within the DDSE (Digital Delivery, Strategy & Engagement) team within DDaT. There has also been wider training provided by the benefits lead, with a development session provided to the wider team.

A draft benefits framework has been developed, based on the APMG (Association for Project Management Group) framework, which sets out the principles of benefits management and the benefits cycle, is clear about what a benefit and disbenefit is, requires realistic benefits to be identified with stakeholders before initiation and then tracked, with benefits being owned by the service.

The framework also includes key templates for use within projects, including a project benefits approach document, benefits register, benefits profile template and stakeholder engagement register.

The templates are being actively developed using the MH (Mental Health) project as an example to ensure that they work as intended and fit the organisational needs. As such although they are not all yet complete, there is assurance that once finished the framework will deliver a full benefits management package.

A key document within the framework is the benefits approach for projects, this enables project specific benefit strategies and forms part of the PID (project initiation document). This reduces replication, enables consistency and clarity over the project benefits.

The benefits framework is clear over the need for engagement with services and the ownership of benefits. We note a cultural change with increased service lead digital projects, with the SRO (senior risk owner) for projects now being from the service, improved structures for stakeholder engagement and integrated working between the benefits and change functions within DDaT.

Objective 2: Benefits focussed digital business cases show the value that project or programme will achieve by the proposition in the business case, by identifying specific benefits that will be achieved, with the current position being baselined.	Reasonable

Overview / Summary of Observations

Training has been provided to key DDaT staff on building better business cases and in general DDaT use the 5-case model for business cases, although there is some consideration of a cut down version for smaller, local investments.

Digital business cases have always considered benefits; however the new benefits framework has improved the processes for stakeholder involvement in identifying, validating, quantifying and baselining benefits.

The framework is clear over the need for full engagement with the user service, and the need to have benefit owners within the service. Benefits are identified and agreed with stakeholders via workshops and defined within the benefits profile document which is used to record service agreement. This process enables business cases to be benefits focussed and links the objectives to the anticipated benefits.

In order to move to a fully clinical / stakeholder led digital projects as opposed to DDaT, the culture within the Health Board needs to change to enable that. From our discussions we note that this is happening, with the newest project considered MH (Mental Health) showing this.

We note that this requires the services to prioritise and enable resourcing to do this work during an already pressured time. For the MH project we note that there are regular meetings with the service and benefits lead to develop relationships and complete the benefits work and the service understands that the benefits are theirs and not DDaT. However, sharing the digital benefits framework on a wider basis across the Health Board may assist the culture change.

Our testing confirmed that benefits have always been considered within business cases, however there is more rigour applied in current cases with greater stakeholder involvement.

The MH project has clear benefits information within the business case and PID with detailed information on type, value, metric, baseline, target, timeline; benefits feed into financials, with assumptions noted and the completion of the benefits approach as per the framework. Older projects include some benefits information however the detail is less, with baselining not always occurring and service ownership is not defined.

Our testing did note that resourcing for benefits leads was not always included within business cases, both from the DDaT and the service perspective. Without clearly including this as a resource / time requirement the framework may not be fully utilised.

Key Findings	Risk & Impact	Agreed Management Action

1	**Benefits Resource** Our testing did note that resourcing for benefits leads was not always included within business cases, both from the DDaT and the service perspective.	Benefits may not be achieved	**Agreed Action(s):** 1) Review of business case templates (SOC, OBC, FBC, Single Stage) to ensure that they include resources for benefits leads from the service and within the core project team where appropriate. 2) Review of the Gateway Review questions to ensure they include focus on the required benefits resources for each project phase (Feasibility, Start-Up, Initiation, Delivery, Closure, Post-Project).
			Expected Evidence of Implementation: 1) Updated business case templates including section for benefits resources where appropriate. 2) Updated Gateway Review questions relating to benefits resources.
		Medium Priority	**Officer:** 1) Digital PPMO Manager 2) Digital PPMO Manager
	Theme: Resourcing	Control Operation	**Target Implementation Date:** 1) 31st January 2026 2) 31st November 2025

Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue.	Limited

Overview / Summary of Observations

There is an acknowledged weakness with DDaT in the realisation of benefits post implementation. Whilst a benefits management strategy was previously extant, the post implementation tracking of benefits wasn't undertaken fully. As such the new benefits framework seeks to address this.

The benefits framework includes the realisation and review stages of benefits management with a requirement for monitoring of benefits and the inclusion of a template benefit register for recording and tracking benefits. The framework also enables realisation by the inclusion of the benefit profile template to record details of benefits and agreement of ownership held by the service.

DDaT is seeking to move towards a product management approach which will enable the optimisation of products on an ongoing basis and so better enable benefit delivery post implementation by ensuring uptake and effective use. However, we note that this is a developing skill, with only 1 product manager in place.

The realisation and reporting aspects of the benefits framework are still being developed, with the MH project being used as a work through. We note that the framework is seeking to link the monitoring of benefits to key data sources in order to simplify the collection of data for reporting.

The framework also sets out a requirement for tolerance levels for benefits realisation, as such it recognises that there may be some drift but sets clear boundaries for when escalation or remediation should be enacted, with the specific thresholds and escalation processes being defied within the project specific benefit realisation plans.

Our testing confirmed that the MH project has a completed benefits approach which sets out the activities within each of the benefits management stages and is clear over service leads involvement and ownership, however this project is not yet at the realisation stage. For older projects, although benefits registers have been created, the detail is not as complete as per the framework, with metrics and owners not always identified and no realisation plan.

Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes with this aspect of the framework still under development. We note that highlight reports are regularly produced for project governance and these for include a benefits section. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital projects.

Key Findings	Risk & Impact	Agreed Management Action

2	**Benefits Reporting** Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital projects.	Lack of clarity over achieved benefits	**Agreed Actions:** 1) Agree benefits reporting and escalation structure within the Digital Data and Technology (DDaT) Team. 2) Agree benefits reporting structure with the Executive Team to demonstrate the value of projects across various BCUHB governance groups outside of the DDaT Team. 3) Review the Benefits Framework to include updated reporting and escalation routes. **Expected Evidence of Implementation:** 1) Benefits reporting and escalation structure within DDaT approved by DPDG. 2) Benefits reporting governance structure outside of DDaT approved by the Executive Team. 3) Benefits reporting and escalation routes fully defined within the Benefits Framework.
		High Priority	**Officer:** 1) Digital Benefits Lead & Digital PPMO Manager 2) Assistant Director of DDSE 3) Digital Benefits Manager **Target Implementation Date:** 1) 31st December 2025 2) 31st March 2026 3) 31st March 2026
	Theme: Performance Monitoring	Control Design	

Objective 4: Digital programmes include business change management activities, including the identification of required business change, revised ways of working, training and ongoing change management.	Reasonable

Overview / Summary of Observations

DDaT have been improving their change management approach, with a change manager in post since 2023, an additional post on a fixed term contract and the development of a formal change management framework.

There is a draft Change Management Framework in place which clearly states the principles, notes the need to change culture, that service users need to be involved, that a change management approach is required for each project and aims to embed change with the provision of a toolkit with key documentation.

The change framework contains key components including the change maturity self-assessment and the change approach documents. These are to be completed for each project and comprehensively define how change is to be managed and delivered in order to deliver a successful digital transformation by linking project objectives, benefits, stakeholder engagement and the mapping of the activities to deliver the change needed to achieve the future state.

In order to build change skills within DDaT, training has been provided to key staff (project managers) and a consultancy has been used to provide change support and who have mentored the change manager to enable knowledge transfer. We also note that the change manager has provided awareness training within the wider DDaT team.

The use of change management varies within DDaT projects, depending on the scale and the purpose of the project in order to focus the limited resource into areas where change support will have the most impact.

As for benefits, for change management to be fully embedded there needs to be a culture shift. From our discussions we note that this is happening, although resource constraints within user services mean that getting clinical staff time to undertake change activities such as process mapping can be difficult. This is true even when change leads are funded within business cases as recruitment to cover the released staff time is problematic. In order to help to resolve this, work is ongoing to define change agents and champions.

As for the benefits framework, the MH project is being used to full test the change management framework and documentation in order to ensure that it works for the organisation.

Our audit testing confirmed that change management has always been considered within projects, however there is more rigour applied in current cases with greater stakeholder involvement. We note that more recent projects have greater clarity over the approach to change, and include resourcing for change leads both from DDaT and the service, however resourcing of this on an ongoing basis within all projects is not guaranteed.

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**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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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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Community services

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2526-17
Fieldwork	July - September 2025
Executive Sign Off	29th October 2025
Audit Committee	December 2025
Executive Lead	Tehmeena Ajmal, Chief Operating Officer
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Laura Howells, Internal Audit Manager

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Executive Summary

Purpose

To review the governance arrangements in place for the management of community services provided by the Health Board. As part of the audit, we considered the following areas:

- Podiatry
- Community midwifery
- Health visiting

We have not reviewed specific performance data against expected metrics.

Overview

There is clear evidence of governance and monitoring within each service, with performance data collected, reported, and monitored. However, there are gaps in assurance provided to the Health Board on community services.

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- Regular performance monitoring is undertaken at an operational and Integrated Health Community (IHC) level, however, there is limited evidence the Board or its Committees receive regular assurance on the performance and quality of community services.
- A risk has been raised by Podiatry that patients with diabetic foot ulcers may not be seen promptly due to the vacancy of an Orthopaedic surgeon with an interest in diabetic foot surgery, with escalation to the Central IHC Patient Safety Quality Group in January 2024, however the issue is still unresolved.
- Meetings show ongoing vacancies in Health Visitor posts, with risks linked to service delivery, Healthy Child Wales Programme (HCWP) performance, and safeguarding.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

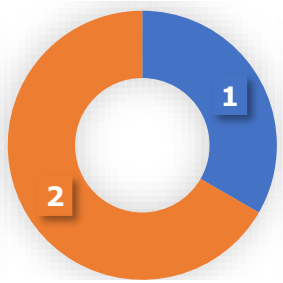
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There are appropriate governance structures in place to ensure effective oversight of community services, including assurance provided to the Health Board.	1 & 2	**Reasonable**
2	There is performance data (qualitative and quantitative) available to support delivery of community services. Information is reported via an appropriate forum, ensuring that services issues are identified, escalated and addressed promptly.	3	**Reasonable**

Management Actions

1	2
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Community Services - Performance

Each of the services reviewed provided an overview of performance metrics which we have not validated:

Podiatry - April 2024 – March 2025

Performance Measure	April 24 – March 25
Total New Assessments	9,912
Total Follow-up Appointments	24,408
Total Activity (patient contacts)	34,320
Musculoskeletal (MSK) Assessments	2,363 (23.8% of all new referrals)
MSK Follow-ups	1,493

Community Midwifery – July 2025

Performance Measure	July 2025			
Area	**BCU**	**WEST**	**CENTRE**	**EAST**
Number of deliveries in BCU	495	145	156	194
Number Booked for Home Confinement	-	-	9	-
Number of Home Births	5	-	5	-
Number of patients discharged	296	118	50	128
% of babies breast feeding at birth	64%	65%	54%	72%
Continuity of Care	65%	-	80%	-
Those with a report of Smoking at Booking	84	16	35	33
Those with a report of Smoking at the onset of Labour	69	13	25	31

Health Visiting – January - December 2024

Area	Contact at 10 - 14 days	Physical examination at 6 weeks	Weight and measurement at 8 weeks	Weight and measurement at 12 weeks	Weight and measurement at 16 weeks	Contact at 6 months	Health visitor contact at 15 months	Health visitor contact at 27 months	Contact at 3.5 years pre-school	All contacts
Wales	91.81	82.46	79.61	75.55	75.19	88.49	86.09	83.76	77.60	82.25
BCU	93.57	89.75	88.63	86.70	87.93	92.00	89.32	85.87	80.49	88.13

Findings & Agreed Action Plan

Objective 1: There are appropriate governance structures in place to ensure effective oversight of community services, including assurance provided to the Health Board.	**Reasonable**

Overview / Summary of Observations

Health Visiting

Health Visiting has a clear governance framework, with responsibilities defined through the three Integrated Health Communities (IHCs). Clinical Service Managers hold responsibility for Health Visiting alongside other children's services, reporting through nursing and children's services leadership. Oversight is provided through local team meetings, Senior Management Team (SMT), and Patient Safety and Quality (PSQ) groups, with issues escalated to the Community Health Clinical Advisory Group (CAG). The CAG terms of reference note its purpose as to maintain and develop robust and sustainable services for children, young people and their families across North Wales and details options for escalation of issues. CAG is accountable to BCU's Children's Service Group. Meeting minutes show information on the service is discussed regularly, covering workforce, safeguarding, digital systems, and performance against the Healthy Child Wales Programme (HCWP).

Podiatry

The service reports through team leads to the Head of Podiatry within each IHC, into Therapy Management Groups (TMGs), and onwards into IHC governance structures. The TMG terms of reference confirm Therapies' inclusion across multiple governance groups, with escalation routes noted. Podiatry is represented in TMG and Senior Leadership Team meetings. Meeting minutes confirm regular discussion of service issues including waiting lists, training compliance, sickness absence, and capacity challenges. Risks, such as those raised by the diabetic foot service, are reviewed in Local Delivery Group (LDG) reports, with actions agreed. Escalation processes are evident through Risk Management Groups, PSQ meetings, and Health and Safety forums, ensuring therapy service risks (including Podiatry) are considered at the appropriate level.

Community Midwifery

Community Midwifery is delivered as one service and not split across each of the IHCs. Local meetings feed into Women's Services Quality, Safety and Experience (QSE) group and then the Women's North Wales Service Board for strategic oversight. Terms of Reference define escalation through assurance and exception reporting. Risk management procedures support these processes. Minutes from QSE, Antenatal, and Postnatal Forums confirm that community performance, pathways, and screening are discussed, with actions recorded. Local team meetings also provide operational oversight. Escalation is evidenced in Forum minutes, where issues of significance are highlighted for QSE consideration.

Board reporting and assurance

There is limited evidence that assurance on community services is provided to the Board, via its committees.

Key Findings		Risk & Impact	Agreed Management Action
1	**Health Visiting Vacancies** SMT and CAG minutes record ongoing vacancies in Health Visitor posts, with risks linked to service delivery, HCWP performance, and safeguarding. Reports highlight workforce shortages as a standing issue for escalation. Management should review outstanding vacancies and ensure these do not pose a material risk to delivery of the HCWP.	Service delivery pressures and safeguarding concerns due to insufficient staffing and inability to meet HCWP requirements.	**Agreed Action:** The vacancy position for Health Visitors is under ongoing review. At the time of the audit West IHC was at full complement, with significant vacancy gaps in Centre and East. Within the last 3 months both IHCs have run recruitment days and all student Health Visitors (SCPHN) have secured jobs. The majority of the vacancies have been filled with a start date of January 2026 when they qualify. Recruitment process continues for the remaining gaps which totals 6.15wte in East with interviews planned and 3.4wte in Centre IHC.
			Expected Evidence of Implementation: Workforce establishment (Health Visitors)
		Medium Priority	**Officer:** Associate Director Childrens Services Central IHC
	Theme: Resourcing	Control Operation	**Target Implementation Date:** 31st March 2026
2	**Reporting / assurance to Board** Although there is evidence that community services are managed and performance is monitored throughout the IHCs, there is limited evidence that regular performance reporting is sent to the Board or its Committees. This gap in monitoring has been noted at Planning, Population Health and Partnerships Committee and at its Meeting on 4 September 2025 it was confirmed the Committee would have oversight of primary care. (Health Board Meeting 25 September 2025 Item 25/169 Chair's Assurance Report - Planning, Population Health and Partnerships Committee).	Poor performance or emerging issues in community services may go undetected, resulting in reduced service quality or failure to meet community needs.	**Agreed Action:** Further to decision at PPHP committee in September to have oversight of primary and community care services, the cycle of business will include regular reporting for primary and community care services, the frequency of reporting is being determined. A development session was held in September with the Chair of the PPHP Committee with wider IMs, Execs and representation from primary & community care lead to discuss the role PPHP can play in contributing to the Strategic Direction of the Organisational Strategy and IMTP covering primary and community, prevention and population health, strategic planning and engagement with Stakeholder. The committee will receive reports relating to the range of community and primary care services, which are monitored via the Primary care Board chaired by the COO (which has recently been expanded to include community services), and via the three IHCs to the monthly operational leadership Group.
			Expected Evidence of Implementation:

			PPHP Cycle of Business / Notes of Committee meetings
		Medium Priority	**Officer:** Chief Operating officer
	Theme: Performance Monitoring	Control Design	**Target Implementation Date:** 31st December 2025

Objective 2: There is performance data (qualitative and quantitative) available to support delivery of community services. Information is reported via an appropriate forum, ensuring that services issues are identified, escalated and addressed promptly.	**Reasonable**

Overview / Summary of Observations

Health Visiting

Performance indicators for Health Visiting focus on delivery of the Healthy Child Wales Programme (HCWP). Additional checks include data quality, with procedures requiring timely entry into the Child and Young Person Record Information System (CYPrIS) system, monthly monitoring reports, and quarterly audits of breastfeeding data.

Reports reviewed showed both quantitative data and qualitative narrative. Reports are produced detailing performance trends and risks. Recent reports highlighted a slight fall in performance linked to staffing gaps, but also noted that local areas remain strong nationally. Performance information is presented at operational meetings (e.g., Band 7, Community Programme Team (CPT), SMT, and CAG), and escalation routes are in place. Examples were seen of issues, such as mastitis management, being raised and resolved appropriately.

Podiatry

Performance information for Podiatry is reported within the Therapies end-of-year Performance Report, covering referral volumes, waiting times, RTT compliance, workforce, and finance. Additional oversight occurs through monthly accountability meetings within each IHC where workforce, financial performance and waiting lists are discussed, and through TMG and SLT forums, which provide standard agendas for reviewing service delivery, risks, and escalation.

Issues that cannot be resolved at operational level are escalated to IHC committees such as Patient Safety & Quality (PSQ), Local Infection Prevention Group (LIPG), or Quality Local Delivery group (QLDG), depending on the area. Evidence was provided of an example in January 2024 where a Central Podiatry issue was escalated through PSQ to support recruitment of a specialist orthopaedic surgeon.

Community Midwifery

Performance monitoring for Community Midwifery uses the Community Dashboard, Antenatal Screening Wales (ASW) indicators, and Newborn Bloodspot Screening Wales (NBSW) standards. These track a range of measures including early booking, smoking cessation referral, BMI pathway compliance, breastfeeding, and screening timeliness.

Reports are reviewed through local team meetings and strategic groups including the Antenatal Forum and the Women's North Wales Service Board. Issues are first managed at team level and, if necessary, escalated through Datix and discussed at the appropriate forum. Significant risks are raised and, where required, passed to the Service Board. Meeting minutes confirmed regular review and escalation.

Key Findings		Risk & Impact	Agreed Management Action
3	**Podiatry – Vacancy** A risk was escalated by Central Podiatry in January 2024 through the Chair's highlight report for the Central Therapies Quality and Safety group. The risk was that patients with a diabetic foot ulcer may not be seen in a timely manner by an orthopaedic surgeon due to there being a vacancy. Support for the recruitment of an orthopaedic surgeon for Central with an interest in diabetic foot surgery who would be able to operate on necessary patients was given. However, this issue has not been resolved and continues to be discussed. Recruitment issues were raised in the Central Vascular Working Group in July 2025 and escalated again.	Risk to quality of care and treatment outcomes for high-risk diabetic patients without recruitment.	**Agreed Action:** The Director of Allied Health Professions is reviewing the previously approved vascular business case (Oct/Nov 2025) to confirm whether funding for the post was included in the case and will be progressed via the surgical directorate. Meanwhile alternative sources of funding will identified within the IHC budget.
			Expected Evidence of Implementation: IMTP confirming funding for post
		High Priority	**Officer:** Director of AHPs (Central IHC) **Target Implementation Date:** 31st March 2026
	Theme: Resourcing	Control Operation	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **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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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

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Shared Services Partnership
Audit and Assurance Services

Contract management and procurement review – Corporate Directors

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Local Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-37
Fieldwork	August - October 2025
Executive Sign Off	1 December 2025
Audit Committee	December 2025
Executive Lead	Carol Shillabeer, Chief Executive
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review procurement and contract management within Executive Director and Director corporate functions.

Overview

Procurement engagements: A review of procurement engagements from 1 April 2024 to 6 August 2025 identified breaches in compliance with the Health Board Standing Financial Instructions (SFI). We found SFI 11.19 No Purchase Order, No Pay (11.19.2) routinely not achieved with retrospective requests for purchase orders to facilitate payment. Executive and Corporate Directors should ensure SFI compliance is at the fore of all financial related decisions and familiarise themselves with the updated requirements set out in SFI 11: Procurement and Contracting for Goods and Services.

Certain Direct Call Off frameworks have been chosen by Health Board officers without prior consultation with NHS Wales Shared Services Partnership (NWSSP) Procurement Services, which may affect the assessment of best value. The use of procurement waivers has remained limited, reflecting increased management controls; however, there are many direct call-off framework awards without Procurement involvement which could impact assurance the Health Board is delivering best value.

There remain internal control matters regarding the signing of contracts between the Health Board and its suppliers. Whilst the revised Scheme of Reservation and Delegation (SoRD) details approval limits and posts delegated to sign (Tier 1 to Tier 5 only[1]), it is unclear how this control will be assured for compliance. We are aware that no post titles, from all corporate and operational SoRDS, have been provided to Procurement Services who act as a key backstop control in this.

Training Attendance: *Welsh Health Circular (WHC/2024/013) Governance on interim appointments to Executive and Senior Positions* states, *"Procurement training is mandatory and must be in place for all Executive Directors and all staff involved in procurement."* Our review of officers with delegated authority, who had approved requisitions in our sample, against training records provided by the Finance Directorate identified poor uptake in the training offered.

Budget Manager Accountability Agreements: SFI 5.2.1 states *"The Chief Executive may delegate, via the Executive Director of Finance, the management of a budget to…The budget holder must sign the accountability letter formally delegating the budget."* SFI 5.2.6 further clarifies *"All budget holders will sign up to their allocated budgets at the commencement of the financial year".* There is generally poor compliance with these Instructions; at the time of our review four (4) of fourteen (14) officers had signed their respective Accountability Agreement (updated position confirmed with Finance 2 October 2025).

Declarations of Interest (DOI): Health Board Policy *OBS02: Standards of Business Conduct* requires Directors to identify *"..other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest….",* with the NWSSP Procurement Manual further outlining scenarios for officers to declare interests. Through our review no officers outside the bands and roles defined have been identified by Directors. The Health Board should consider requiring all officers with delegated limits who approve purchase order requisitions, to complete annual declarations of interest.

Again, we must report that we did not receive evidence in line with Standing Financial Instruction 3.2.2; we agreed to extend the timeline for a response from People & OD but did not receive a reply.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

[1] https://bcuhb.nhs.wales/about-us/governance-and-assurance/standing-orders-and-financial-instructions/standing-orders-schedule-1-sordpdf/ - Healthcare Agreements / Contracts with non-NHS bodies (Page 61/116)

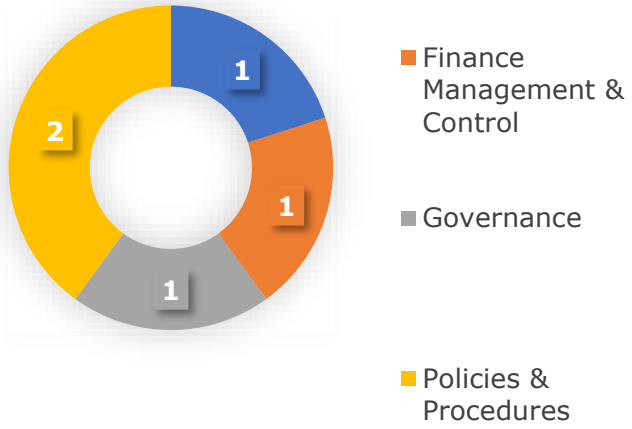
Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	1	**Limited**

Management Actions

5	-
High Priority	Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Financial Loss

Standing Financial Instruction compliance - At a Glance

Review of Corporate Directors compliance with Standing Financial Instruction (SFI) 11.19 No Purchase Order, No Pay:

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

Days variance between the recorded Invoice Date and the Purchase Order created date

Lower Bound	Upper Bound	Count	Percent of Count (%)	Percent of Field (%)	Line Amount (£)
1 Day	9 Days	467	23.88	10.97	3,392,301.08
10 Days	19 Days	483	24.69	11.06	3,424,156.08
20 Days	29 Days	264	13.5	17.42	5,391,938.12
30 Days	59 Days	329	16.82	40.31	12,475,881.56
60 Days	89 Days	143	7.31	8.91	2,756,235.77
90 Days	119 Days	66	3.37	6.85	2,119,677.82
120 Days	239 Days	126	6.44	3.55	1,100,068.66
240 Days	364 Days	28	1.43	0.68	211,874.61
365 Days	730 Days	44	2.25	0.17	51,505.52
730 Days	1902 Days	6	0.31	0.08	23,351.71
		1,956	100	100	30,946,990.92

Source: Data obtained from Qliksense - Purchase Order and Invoice Header details 6 August 2025; includes all NHS and public sector purchase orders.

Corporate Director cost centres are operating a 6% non-achievement of the SFI 11.19.2, where 1,956 purchase order lines were raised after the invoice date (from a total of 30,863 purchase order lines).

Findings & Agreed Action Plan

Objective 1: To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	**Limited**

Overview / Summary of Observations

The Health Board Standing Financial Instructions (SFIs) set out clear requirements and limits for the procurement of all goods and services, as well as detailing the responsibilities of budget holders.

Review of procurement engagements 1 April 2024 to 6 August 2025

Corporate directors are not routinely complying with the No Purchase Order, No Pay requirement of the Standing Financial Instructions. Whilst this is limited in number, corporate directors should always ensure they comply with the Health Board's governing documents.

Our review of sample data has identified an over-reliance of Direct Call Off (DCO) framework use by officers without NWSSP Procurement involvement. Whilst noting recent changes to the Standing Financial Instructions (due to the *Procurement Act 2023* and *Health Services (Provider Selection Regime) (Wales) Regulations 2025*) lend to greater use of frameworks, this should be planned, agreed and progressed at the earliest opportunity with NWSSP Procurement Services to formalise the best route to market. The use of DCO should not be used as the vehicle to procure goods and services due to insufficient time and/or poor planning. The Health Board, through its IMTP, has already identified the schemes and programmes it wishes to prioritise and lead officers should actively engage with NWSSP Procurement Services at the time of Board approval.

In our sample we found one supplier having three DCOs in the period totalling £1,208,574 and are unclear why market testing had not been undertaken with a contract put in place.

We requested additional information to that provided by NWSSP Procurement Services concerning eleven purchase orders and noted that five (46%) were considered compliant with expected controls. The remaining issues noted unsigned contracts provided and the signing of contracts by officers without delegated authority.

We received no reply to our request for additional evidence from People & OD and are unable to confirm compliance with expected controls.

Training

Our review of records retained by the Finance Directorate of attendees at Finance and NWSSP Procurement training events noted 8% of our sample (one out of thirteen) had attended the training.

Budget Manager Accountability Agreements (BMAA)

SFI 5.2.1 states "The Chief Executive may delegate, via the Executive Director of Finance, the management of a budget to…The budget holder must sign the accountability letter formally delegating the budget". There is limited compliance with the signing of Accountability Agreements by Corporate Directors with ten (71%) of fourteen not having signed their agreement at the time of this review (verified 2 October 2025), six months into the current 2025/26 financial year.

Declarations of Interest (DOI)

Our review has identified there needs to be greater scrutiny by Directors to ensure declarations previously completed are submitted annually and that roles with the potential for conflicts of interest are documented and officers required to submit annual declarations. As a minimum we

consider all roles with a delegated limit, that can commit expenditure on behalf of the Health Board by via procurement and select suppliers, complete annually.

Key Findings		Risk & Impact	Agreed Management Action
1	**Procurement training** Welsh Health Circular (WHC/2024/013) *Governance on interim appointments to Executive and Senior Positions* requires *"Procurement training is mandatory and must be in place for all Executive Directors and all staff involved in procurement".* We obtained details of officers who have attended procurement training from the Finance Directorate who maintain the list of attendees. We noted recently appointed Executive Directors are yet to receive their mandatory procurement training. We reviewed a sample of officers delegated to approve requisitions against the training records held - we found one (8%) of thirteen had attended procurement training.	Compliance with SFI 2.3.2, 5.2.7 and WHC/2024/013 is not evident exposing the Health Board to risk of non-pay expenditure not compliant with Statute.	**Agreed Action:** • Develop and maintain a register of all officers required to complete procurement training exploring the use of ESR to record compliance (Director of Workforce and OD); and • Schedule mandatory sessions for Executive Directors and delegated officers (Director of Workforce and OD) **Expected Evidence of Implementation:** Register of procurement training detailing attendees against those expected to receive training. Consider using the Electronic Staff Record (ESR) training module to stipulate all officers who require procurement training.
		High Priority	**Officer:** Director of Workforce and OD **Date:** 31/12/2025
	Theme: Policies & Procedures	Control Operation	
2	**Accountability Agreements** Accountability Agreements detail explicitly the expectations of Budget Holders, including: *'I will adhere to the Health Boards approved Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, specifically in regards to recruitment and commissioning of goods and services;* *I will attend a mandatory session for Procurement of goods and services (dates to be shared) hosted by Procurement Shared Services for Wales, it is my responsibility to ensure I attend one of the planned sessions once dates are confirmed.* *Ensure as far as I am able that all non-pay expenditure complies with the requirements of the Standing Financial Instructions including the requirement for an official purchase order to be raised in advance of incurring the expenditure'.* The review of data obtained from the Finance Directorate concerning the status of Tier 1 (Chief Executive) and Tier	Compliance with SFI 5.2.1 has not been demonstrated for Tier 2 of the Health Board, which may result in officers not meeting requirements on non-pay expenditure.	**Agreed Action:** • Ensure all Tier 1–2 officers sign Accountability Agreements for 2025/26. • Escalate non-compliance to Audit Committee with reasons for refusal **Expected Evidence of Implementation:** Directors sign the agreements. Where a director does not sign an Accountability Agreement, as set-out in the Standing Financial Instructions, this should be reported to the Audit Committee as a breach of the Instructions with the reasons why they could/would not sign.
		High Priority	**Officer:** Director of Finance and Procurement **Date:** 31/12/2025

	2 (Executive/Corporate Directors) Accountability Agreements, as of 2 October 2025, for the 2025/26 financial year notes nine (64%) recorded as not replied to the request to sign the agreement; one (7%) recorded as refusing to sign the agreement; and four (29%) signing the agreement. We are aware that escalation meetings have taken place however note only one additional Agreement has been signed since.		
	Theme: Governance	Control Operation	
3	**Declarations of Interest (DOI)** Health Board Policy OBS02 Standards of Business Conduct paragraph 8.6 requires *"Mandatory annual declarations of interests are required from….all senior employees (band 8c or equivalent and above),……and also other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director)".* Our review of ninety officers who approved requisitions for a purchase order to be raised found thirty-one (34%) did not have up to date declarations recorded with thirteen (14%) having made no declaration. We were unable to confirm Directors had formally considered the requirement to identify *"....other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director)".* All officers with delegated authority and/or who engage with suppliers have the potential for conflicts of interest when procuring goods and services on behalf of the Health Board.	Adherence to Standing Order 8.3 has not been fully integrated within the Corporate Directorates, which may lead to potential risks related to bribery and corruption.	**Agreed Action:** • Identify all roles with delegated authority or procurement responsibilities via the budget holders register held by Finance • Require annual DOI submissions for these roles. **Expected Evidence of Implementation:** Officers identified where the potential for conflicts of interest exist.
		High Priority	**Officer:** Director of Corporate Governance **Date:** 31/01/2026
	Theme: Policies & Procedures	Control Operation	
4	**Direct Call Off (DCO) framework use** The review of DCO evidence does not demonstrate the Health Board has consistently achieved best value in the selection of suppliers for DCO awards where officers are routinely undertaking DCO with suppliers, without engaging NWSSP Procurement Services first to ensure best route to the market. The NHS Wales Procurement Manual states *"Depending upon the requirement and value of the opportunity, 'direct call off' may not offer the best value solution overall. The lead and Procurement Lead will consider this at the planning stage.*	Some DCO awards may not guarantee best value where Procurement is excluded from decision-making.	**Agreed Action:** • Procurement training to ensure the reduction in Direct Call Off by engaging NWSSP Procurement Services at planning stage. • Monitor and report DCO usage quarterly (via procurement report) **Expected Evidence of Implementation:** An overall reduction in DCO by the Health Board is evident.
		High Priority	**Officer:** Director of Finance/Head of Procurement

	Suppliers should be invited to bid via the Procurement Service appointed e-procurement solution".		**Date:** 31/03/26
	Theme: Contractual	Control Operation	
5	**Compliance with the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD)** There are detailed expected controls in the Standing Financial Instructions, relating to procurement, that have been refreshed to align with the *Procurement Act 2023* and *Health Services (Provider Selection Regime) (Wales) Regulations 2025*). A review of the procurement data in our sample has identified the following SFIs that show inconsistent compliance: • Procurement advice is sought from Procurement Services at the outset (SFI 11.3.6). • Effective planning of procurement exercises with Procurement Services was soon as possible to ensure compliance with minimum competition thresholds (SFI 11.9.2). • For 'Goods and Non-Health Services Only', advice from Procurement Services is sought for all requirements in excess of £5,000 (excluding VAT) (SFI 11.11.2). • No Purchase Order, No Pay where retrospective requests have been made to facilitate payment of an invoice (SFI 11.19). We found instances where contracts between the Health Board and suppliers had not been signed or signed by officers with no delegated authority. We note that some of the contracts are not progressed through Procurement Services but the Health Board's own Contracting Team, with one instance of a contract being signed and dated after our request for sight of the signed copy from our sample.	Non-compliance with Standing Financial Instructions may expose the Health Board to potential legal challenges from suppliers due to insufficient competition.	**Agreed Action:** • Deliver update sessions on revised SFIs and SoRD to all Executive and Corporate Directors. • Notify NWSSP Procurement Services of all delegated officers authorised to sign contracts. • Ensure all contracts are signed by authorised officers before commencement. **Expected Evidence of Implementation:** Executive and Corporate Directors receive an update session on the requirements and expectations laid out in the Standing Financial Instructions and cascade this to their respective management teams. Tier 1 to Tier 5 delegated and authorised to sign contracts per the Scheme of Reservation and Delegation (SoRD) notified to NWSSP Procurement Services. Health Board Contracting Team ensure contracts are signed at the outset and by the officers delegated in the SoRD.
		High Priority	**Officer:** Director of Finance/Director of Corporate Governance **Date:** 31/03/26
	Theme: Finance Management & Control	Control Operation	

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**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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