

Bundle BCU Audit Committee 18 August 2026

- 1 09:30 - PRELIMINARY MATTERS
 - 1.1 AC26.72 Welcome and apologies
Chair
 - 1.2 AC26.73 Declarations of interest
Chair
 - 1.3 AC26.74 To approve the unconfirmed minutes of the previous meetings held on 21.4.26 and 23.6.26
Chair
 - AC26.74a Minutes Audit Committee 26.6.26 v0.1 unconfirmed PUBLIC
 - AC26.74b Minutes Audit Committee 21.4.26 v0.1 unconfirmed PUBLIC
 - 1.4 AC26.75 Summary action log
Chair
 - AC26.75 Summary Action Log public updated 11.8.26 v2.0
- 2 GOVERNANCE, RISK AND ASSURANCE
 - 2.1 09:40 - AC26.76 Update on Outstanding Audit Recommendations - Director of Corporate Governance
Pam Wenger, Director Corporate Governance
 - AC26.76 Open Audit Recs and CRR BAF Risks v1.0
 - 2.2 09:55 - AC26.77 Corporate Risk Register Report
Pam Wenger, Director Corporate Governance
Jody Evans, Assistant Head Risk Management
 - AC26.77a Public CRR AC Report August 2026 v1.00
 - AC26.77b App 1 - CRR - August 2026 - Public
 - 2.3 10:05 - AC26.78 Board Assurance Framework 2026/27 Report
Pam Wenger, Director Corporate Governance
Jody Evans, Assistant Head Risk Management
 - AC26.78a Board Assurance Framework
 - AC26.78b Appendix 1 - Portal - Board Assurance Framework - V1.0 - August 2026
 - AC26.78c Appendix 2 - Extant Open BAF Actions - Mapping to new BAF to carry over (2)
 - 2.4 10:15 - AC26.79 Corporate Governance Report
Pam Wenger, Director Corporate Governance
Philippa Peake-Jones, Head of Corporate Governance
 - AC26.79a Corporate Governance report v1.0
 - AC26.79 Appendix A Cycle of Business Audit Committee 2026-27 v.02 draft
 - AC26.79 Appendix B Audit Committee Self Assessment Presentation 2025-26 v1.0
 - AC26.79 Appendix C Audit Committee Annual Report 2025-26 v.01 draft
 - AC26.79 Appendix D Audit Committee ToR V1.01
 - AC26.79 Appendix E Effective Systems of Governance Plan 11.8.26
 - 2.5 10:30 - AC26.80 Integrated Compliance and Assurance Report

Pam Wenger, Director Corporate Governance
Glesni Driver, Head of Statutory Compliance and Inquiries

AC26.80a Integrated Compliance and Assurance report 18.08.2026 v0.05

AC26.80b App 1 - Summary for AC closure v1.00

AC26.80c App 2 - IA Open Unsatisfactory v1.00

AC26.80d App 3 - IA Open Limited Assurance v1.00

AC26.80e App 4 - AW open v1.00

- 2.6 10:45 - AC26.81 Governance and Accountability Framework - Amendments
Pam Wenger, Director Corporate Governance / Russ Caldicott Executive Director Finance
AC26.81a Governance and Accountability Framework
AC26.81b Schedule 1 - Scheme of Delegation and Reservation of Powers - Draft August 2026
- 2.7 10:55 - AC26.82 Committee Assurance report - Alert, Assurance and Advice reports
Pam Wenger, Director Corporate Governance
AC26.82 Committee Assurance Report AAA report review
- 3 FINANCE
- 3.1 11:05 - AC26.83 Financial Conformance Report
Russ Caldicott, Executive Director Finance
AC26.83 Financial Conformance Report - Q1 2026-27 FINAL V2
- 3.2 AC26.84 Item deferred
- 3.3 11:25 - Break
- 4 INTERNAL AUDIT
- 4.1 11:35 - AC26.85 Internal Audit Progress Report
Dave Harries, Head of Internal Audit
Internal Audit reports provided within supporting papers pack with exception of Centre For Mental Health and Society (BCU-2526-44) which will be reported at agenda item AC26.88
AC26.85a BCUHB IA Progress report August 2026
AC26.85b Audit Committee progress report August 2026
- 5 EXTERNAL AUDIT
- 5.1 12:05 - AC26.86 External Audit Progress Report
Audit Wales
AC26.86 Audit Wales BCUHB Audit Committee Update (August 2026)
- 6 COUNTER FRAUD
- 6.1 12:20 - AC26.87 Local Counter Fraud Service Progress Report
Danielle Timmins, Head of Counter Fraud
AC26.87a Counter Fraud Report Q1 26-27 Public
AC26.87b Appendix A Dashboard Q1 26-27
AC26.87c Appendix B Fighting Fraud Strategy
- 7 REPORTS - FOR DISCUSSION
- 7.1 12:30 - AC26.88 Centre for Mental Health and Society Internal Advisory Review and Wider Research, Development and Innovation Review

Carol Shillabeer, Chief Executive

AC26.88a CfMHS and RDI report v4

AC26.88b BCU-2526-44 Final Advisory Internal Audit report Centre for Mental Health and Societyv3

9 12:40 - CLOSING BUSINESS

9.1 AC26.89 Agree Items for referral to Board / Other Committees
Chair

9.2 AC26.90 Review of meeting effectiveness
Chair

9.3 AC26.91 Date of the next meeting : 20 October 2026

10 12:45 - Resolution to exclude the Press and Public
"representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed minutes of the Audit Committee
held on 26 June 2026
in the Boardroom, Carlton Court, St Asaph and via Teams

Name	Title
Committee Members Present	
Paul Lambert	Independent Member (Chair of Audit Committee)
Urtha Felda	Independent Member
Dyfed Jones	Independent Member (via Teams)
Rhian Watcyn Jones	Independent Member
In Attendance	
Emma Adamson	Associate Member, Chair Healthcare Professionals Forum (via Teams)
Jeff Brown	Digital Audit Manager, Audit Wales (via Teams)
Russell Caldicott	Executive Director of Finance
Glesni Driver	Head of Statutory Compliance & Inquiries
Dyfed Edwards	Health Board Chair (via Teams)
Dave Harries	Head of Internal Audit, NWSSP
Tom Haslam	Director – NHS Performance, Audit Wales
Nicola Jones	Deputy Head of Internal Audit, NWSSP
Justine Parry	Acting Director Digital (via Teams)
Maeve Puleston-Jones	Audit Manager – Performance, Audit Wales
Michelle Phoenix	Performance Audit Lead, Audit Wales
Carol Shillabeer	Chief Executive (via Teams)
Pam Wenger	Director Corporate Governance
Peter Milne	Member of the Public (by invitation via Teams)
David Graves	Member of the Public
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Diane Davies	Corporate Governance Manager (via Teams)

PRELIMINARY MATTERS

AC26.64 Welcome and apologies for absence

The Chair welcomed all attendees to the meeting and extended condolences on behalf of the Committee to family and friends of Sjef Molmans, Deputy Head of Local Counter Fraud Services whom had sadly passed away. His service to the Committee was recognised with grateful thanks.

Apologies were received from Danielle Timmins, and also Fflur Jones, Andrew Doughton of Audit Wales.

In response to Rhian Watcyn Jones, the Director of Corporate Governance assured that draft minutes of the previous meetings would be discussed at the next meeting, as this agenda was primarily focussed on discussion of the draft 2025/26 Accounts and Annual report prior to seeking endorsement for submission to the next Board meeting.

The Committee Chair emphasised the importance of tracking the audit issues and recommendations to avoid repetition in future cycles. He advised that questions that had been received from members of the public prior to the meeting would be dealt with through usual governance procedures, including publication of responses to their individual enquiries on the Audit Committee website page in due course. He recognised the volume of work undertaken across Corporate Teams and Internal & External Auditors to meet designated Welsh Government (WG) timelines.

AC26.65 Declarations of Interest

None were received.

ANNUAL REPORT

AC26.66 Financial Annual Accounts 2025/26

The Executive Director of Finance presented this item and thanked the Finance Team and Audit Wales for their commitment.

He stated that the Final accounts, audited by Audit Wales, confirmed :

£17.3m deficit (aligned with forecast).

Unqualified audit opinion (clean) on financial statements which was a strong achievement.

Qualified regulatory opinion due to failure to meet break-even duty (statutory obligation).

The mis-statement in regard to Assets was being explored however, this was understood to be a system issue and the net position remained the same.

Capital performance:

Within permitted limit (only £69k below threshold).

Good performance on:

Invoice payment timeliness (~96.9%).

The Chief Executive set out the timeline of further Board discussion and recovery approach to be undertaken to enable the organisation's sustainability, indicating that budget holders would be provided with clear targets in order that a value and sustainability scheme pipeline was operational from the end of June 2026.

In the discussion which followed Committee members raised concerns with the absence of a clear, detailed, robust and deliverable financial recovery plan to date, the need for specific savings plans, opportunities to discuss decommissioning services and having clarity on the repercussions of savings decisions. The Committee emphasised the urgency of ensuring the WG requirement to identify Savings plans to underwrite the deficit was required by 30 June and that delays in enacting savings would increase financial pressure later in the year.

The Executive Director of Finance stated that the recovery approach to be undertaken would include Value and Sustainability programmes, "Grip and control" measures as well as Budget holder savings (initial 2% target). The £46m savings plan would be provided to WG by 30 June 2026 and a further £17m savings plan to address the Welsh Risk Pool would be in place by the second quarter. Members questioned how this might affect the IMTP.

It was resolved that the Committee

Endorsed for Board approval the draft Financial Annual Accounts 2025/26

Agreed that a high-level recovery plan overview (to include impacts and timelines) be provided to the next Audit Committee

AC26.67 Annual Report 2025/26

The Director of Corporate Governance presented this item, commending the work undertaken by corporate teams and the constructive relationship with auditors in completing this retrospective annual report which was balanced and honest, reflecting both progress and ongoing challenges. It acknowledged failure against WG's key duties of break even and IMTP planning however, improved progress was also reflected such as governance maturity, workforce stability and retention as well as within areas of planned care (meeting Welsh Government de-escalation criteria).

She highlighted key challenges and pressures in the areas of access, digital provision, finance and workforce and provided a brief overview of some of the work being undertaken to address these areas such as governance processes to improve the timeliness of papers which had lead to regular breaches of standing orders and the commissioning of additional assurance work in relation to procurement and capital governance.

The Committee was keen to be provided with more forward looking trajectories and forecast into the coming year including Benchmarking against other similar organisations and improved insight into complaints trends (not just response times).

The Chief Executive advised discussion of the Annual report would take place at the Annual General Meeting, providing the opportunity for members of the public to submit questions. She stated that Access to Planned and Emergency Care performance was regularly discussed at each Board meeting throughout the year and the Board was also focussing upon procurement contracting. Whilst People indicators were improving due to investment, the Board was directing attention to Culture to enable longer term improvements and stability. She advised, as Accountable Officer, that she was satisfied with the infrastructure of systems of control, risk-based planning and that key development areas were identified and being dealt with in a transparent manner.

Rhian Watcyn Jones commended the improved standard of coherent report drafting, Dyfed Jones complimented the 'easier read' style of the report. He also emphasised the need for the NHS to balance the need for financial control and savings restraints with meeting performance targets to ensure it meets the needs of the population. He felt it important to understand the effective ratios of employees to ensure the right blend of workforce for the community they serve.

The Health Board Chair thanked all involved in preparation of the report and the growing relationship with internal and external audit. He stressed the Board's ambition to be a high performing deliverer in all areas of the organisation, improving on scrutiny of the benefits realisation of all investment decisions. It was important to look at everything 'in the round' and ensure effective governance, finance and performance was always considered.

It was resolved that the Committee



Endorsed for submission to Board the draft 2025/26 Annual Report

Agreed that forward projections be included alongside retrospective reporting in future.

Agreed that improved comparable benchmarking analysis (internal and external) be provided in future reporting.

Agreed that further insights be developed into monitoring Complaint themes and trends.

INTERNAL AUDIT

AC26.68 Head of Internal Audit (IA) Opinion & Annual Report 2025/26

The Head of Internal Audit presented this item advising that the annual opinion for 2025/26 was of **Limited Assurance**.

He highlighted that the overall audit programme had delivered 33 of 35 reviews and commended the first substantial assurance review rating in years, which was an internal audit review of asbestos management. However, there were significant concerns regarding Procurement non-compliance with Standing Financial Instructions (SFIs).

Continued weaknesses in capital governance (second year unsatisfactory opinion).

Poor management response rates (down to ~64%).

Failure to provide evidence in some cases (SFI breach).

Only 58% of follow-up actions closed.

In discussion of the report, the Committee received the following assurances:

The Chief Executive had instigated discussion to improve executive response times, albeit acknowledging their significant capacity issues

Digital procurement and governance was improving under the acting leadership of Justine Parry and was continuing to be an area of focus within Executive team meetings.

Improvements to capital schemes and their management was currently receiving high priority focus by the Executive Director of Finance.

The remaining IA reports would be discussed at the August Audit Committee meeting.

The Committee Chair emphasised that improved governance would lead to better schemes which could be well served with effective monitoring and follow up reporting. Dyfed Jones commended the internal audit service in providing opportunities to make improvements whilst the organisation was on its improvement journey.

It was resolved that the Committee

Noted and received the Head of Internal Audit opinion and annual report for 2025/26

Agreed the following **actions**:

Chief Executive to hold Executive Directors to account for response timeliness and improve close-out rates of audit recommendations.

Director of Corporate Governance to provide breakdown of response rates by Executive.

Consider digital data governance oversight and structure at a future Committee meeting.

EXTERNAL AUDIT



AC26.69 ISA 260 Audit of Financial Statements

Michelle Phoenix, Audit Wales presented the Audit of Financial Statements advising the key findings were:

Unqualified opinion (true and fair).

Qualified Regulatory opinion due to failure of financial duty.

Key issues were weaknesses in Performance report quality and Governance of executive remuneration.

The Committee Chair welcomed the Director of Corporate Governance's assurance that she had taken steps to improve and strengthen governance of the Remuneration Committee.

It was resolved that the Committee

Recommended approval of the Annual Report and Accounts to Board (for submission and Auditor General sign-off).

AC26.70 Audit Wales progress report

Tom Haslam was welcomed to his first BCUHB Audit Committee as Director, NHS Performance for Audit Wales to present the Audit Update and Strategic Funding letter. He outlined the changes being made to future Structured Assessments in regard to governance including deeper dives focussed on arrangements, implementation and delivery as designed. The Foundations for the Future (FftF) programme would be monitored closely, the Chief Executive sought early discussion with Tom Haslam and Andrew Doughton, Audit Wales at an early stage as she stressed the importance of ensuring the effectiveness of the programme in delivering sustainable and long term success. The Director of Corporate Governance welcomed working together with the new approach, particular in regard to the focus on outcomes.

In regard to the **Strategic Funding letter**, whilst Tom Haslam explained there had been no fraudulent use of strategic funding, there was weakness in tracking part of the expenditure which he acknowledged had been spent on service delivery and was now addressed with more robust processes. The Executive Director of Finance outlined the improved approach being undertaken with strengthened business cases and benefits realisation at the Performance, Finance and Information Governance Committee. **The Chief Executive undertook to address this with a formal management response.**

The Health Board Chair emphasised the importance of ensuring that BCUHB's governance structure ensured that benefits realisation was integral and visible. He stressed the importance of the Board's need for clarity on the improvements and benefits delivered on any investments made and ensure this was demonstrated to the Public.

In response to Urtha Felda, Tom Haslam advised that all benefit realisation (not only financial benefits) should be incorporated and monitored from the inception of any programme management approach to investments. He undertook to contact WG for any further beneficial evaluations that might be helpful to gain further learning in this area.

It was resolved that the Committee

Noted the Audit Update and Strategic Funding letter

(Dyfed Jones left the meeting)

The **Quality Governance report** was presented by Maeve Puleston-Jones, Audit Manager, Audit Wales. She highlighted the progress made in areas of governance structures, complaints and mortality as well as gaps in areas such as lack of clarity on quality priorities, leadership consistency, learning from incidents and assurance on commissioned services.

In the discussion which followed the Committee expressed their disappointment in the failures to embed learning and the Quality Management System (QMS). The Chief Executive provided assurance on the steps being taken to address the report findings and the intention to improve the organisation's effectiveness through ensuring these were co-existent with the Foundations for the Future improvements. The Executive Director of Finance also provided assurance that, having had the Commissioning Framework endorsed by the Board, strengthened improvements were being moved forward. Progress on the report findings would be monitored by the Quality, Safety and Experience Committee. The Committee Chair was keen to ensure that oversight of the QMS system and lessons learned were addressed within the committee governance system.

It was resolved that the Committee
Noted the Quality Governance report

The **Digital Transformation Review** was presented by Jeff Brown, Digital Audit Manager, Audit Wales. Whilst he reported that there had been significant digital delivery activity, there were weaknesses in not having a fully aligned/Board approved strategy and unfunded roadmap. The governance and oversight was not sufficiently robust, with a limited understanding of digital skills capability within the workforce and low digital maturity baseline that encompassed in excess of 400 legacy systems. The Acting Digital Director provided a brief overview of actions being undertaken to address these areas, highlighting priority focus on clinical systems and the significant impact of inflationary costs, despite significant investment being allocated to digital resources.

The Chief Executive provided context of the national environment which was constrained by a lack of fully funded all-Wales digital strategy and "Once for Wales" approach which impacted local flexibility.

In conclusion the Digital Audit Manager advised there was a likelihood of an all Wales report being drawn together to provide a national context. The Committee Chair emphasised the need for digital systems which were fully integrated to provide safe, effective and timely healthcare.

It was resolved that the Committee
Noted the Digital Transformation Review report

COUNTER FRAUD

AC26.71 Local Counter Fraud Annual Report 2025/26



The Executive Director of Finance presented this item. The Local Counter Fraud Service had delivered a consistent and effective level of activity throughout 2025/2026, demonstrating improvements in investigation outcomes, fraud prevention, and staff engagement. Overall assurance remained acceptable, with no issues requiring escalation and continued evidence of strengthened organisational fraud control arrangements.

In respect of the annual Counter Fraud Functional Standard Return (2025/2026), the self assessment had been rated as GREEN and submitted on time.

The Committee commended the standard of report writing and, whilst acknowledging the imbalance of service costs against financial recovery, commended the service provided to the organisation. It was suggested that future reporting should also quantify the benefits of non-financial costs especially in regard to value provided in areas such as workforce education.

It was noted that the Director of Corporate Governance was working with the Head of Counter Fraud to prioritise improvements to the Declarations of Interest and Gifts and Hospitality processes.

It was resolved that the Committee

Noted the Local Counter Fraud Annual Report 2025/26 and submission of the Counter Fraud Functional Standard Return (2025/2026).

CLOSING BUSINESS

AC26.72 Date of next meeting - 18.8.26

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed minutes of the Audit Committee
 held on 21 April 2026
 in the Boardroom, Carlton Court, St Asaph and via Teams

Name	Title
Committee Members Present	
Paul Lambert	Independent Member (Chair of Audit Committee)
Rhian Watcyn Jones	Independent Member (via Teams)
In Attendance	
Tehmeena Ajmal	Chief Operating Officer (part meeting)
Russell Caldicott	Executive Director of Finance (via Teams)
Clara Day	Executive Medical Director (part meeting)
Glesni Driver	Head of Statutory Compliance & Inquiries
Dyfed Edwards	Health Board Chair
Dave Harries	Head of Internal Audit, NWSSP
Matt Joyes	Deputy Director Legal Services
Fflur Jones	Performance Audit Lead, Audit Wales
Nicola Jones	Deputy Head of Internal Audit, NWSSP
Stuart Keen	Director Estates and Environment
Michelle Phoenix	Performance Audit Lead, Audit Wales
Danielle Timmins	Head of Local Counter Fraud
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Diane Davies	Corporate Governance Manager

PRELIMINARY MATTERS

AC26.26 Welcome and apologies for absence

The Chair welcomed all attendees to the meeting and, in response to his question, received confirmation that Committee members had received all papers within an appropriate timeframe for consideration prior to the meeting. He therefore confirmed that the papers would be considered as read.

Apologies were received from Pam Wenger Director Corporate Governance, for whom Matt Joyes deputised, Urtha Felda and Dyfed Jones Independent Members.

AC26.27 Declarations of Interest

No declarations of interest were received.

AC26.28 Unconfirmed Minutes of the meeting held on 17 February 2026

The Committee considered the unconfirmed minutes of the meeting held on 17 February 2026.

It was resolved that the Committee:

- **AGREED** the minutes of the meeting held on 17 February 2026 as a true and accurate record.

AC26.29 Matters Arising and Action Log

The Committee reviewed the action log and progress against outstanding actions.

Members raised concern regarding the level of slippage across a number of actions and emphasised the importance of agreeing realistic and achievable timescales rather than repeatedly revising deadlines.

Discussion focused in particular on actions relating to the Performance Framework and the Commissioning Assurance Framework. The Executive Director of Finance and officers advised that delays had arisen due to portfolio changes following the departure of the Director of Performance and Commissioning, with responsibility subsequently transferring into the Finance portfolio. Updated timelines were provided, including confirmation that the Commissioning Assurance Framework was scheduled for consideration by the Executive Committee on 6 May, followed by Board consideration later in May.

Members stressed that actions should only remain open where there was clear ownership, delivery intent and appropriate committee oversight. It was agreed that revised timescales should be amended within the action log where delivery could not reasonably be achieved within the original deadlines.

Members discussed whether matters arising from the previous meeting had been appropriately reflected within the action log. Clarification was provided regarding issues raised in respect of document accessibility and internal audit reporting, and it was agreed that these would continue to be monitored through ongoing agenda items rather than treated as discrete actions.

It was resolved that the Committee:

- **NOTED** the action log and progress updates provided; and
- **AGREED** that revised, realistic timescales should be reflected where necessary

AC26.30 Update on Outstanding Audit Recommendations

The Executive Director of Finance introduced the report on outstanding audit recommendations and highlighted that delivery of audit actions was treated as a priority within his portfolio. He outlined the key areas covered by the report, including the Performance Framework, Commissioning Assurance Framework, major projects, and value and sustainability.

Members challenged whether the information presented sufficiently demonstrated how the Health Board would ensure delivery over the coming 12 months, noting that while narrative updates were provided, clearer milestones, governance routes and committee escalation arrangements were required to support assurance.

The Committee discussed the risk of reporting activity rather than progress and emphasised the importance of demonstrating how recommendations translated into



sustained improvements in oversight and control. Members sought assurance that internal audit follow-up activity would be appropriately timed to provide meaningful assurance on implementation rather than premature confirmation. Officers confirmed that internal audit follow-up work would be planned once frameworks and governance arrangements were embedded, and that future reporting would seek to be clearer on oversight routes and anticipated milestones.

It was resolved that the Committee:

- **NOTED** the update on outstanding audit recommendations; and
- **REQUESTED** future reports demonstrate clearer governance structures, delivery milestones and escalation routes.

AC26.31 Corporate Governance Report

The Head of Corporate Governance presented the Corporate Governance report, including information relating to late submission of papers and the Committee's forward work plan. Members reiterated concern regarding the continuing impact of late paper publication on the Committee's ability to exercise effective scrutiny. It was acknowledged that while work had been undertaken to improve report quality and author awareness, further improvement was required to embed timely submission as routine practice.

Clarification was provided in relation to items shown as closed within the forward work plan, including consultant job planning, clinical audit, and the Centre for Mental Health and Society. Members noted that while some items were technically closed following receipt of reports, underlying work in several areas remained ongoing through other governance routes.

It was resolved that the Committee:

- **NOTED** the report

AC26.32 Corporate Governance Improvement Programme

The Head of Corporate Governance presented the inaugural report on the Corporate Governance Improvement Programme, which consolidated actions arising from the Structured Assessment and other governance priorities.

Members welcomed the development of a single improvement framework and recognised it as a positive step. However, challenge was raised regarding the absence of interim milestones and clarity on how progress would be demonstrated over time, particularly given the significance of the issues being addressed.

Discussion focused on the importance of evidencing improvement throughout the year rather than relying solely on year-end milestones. Members highlighted overdue policies and board effectiveness as areas where interim assurance would be particularly important. Assurance was provided that the framework was in its early stages and would be strengthened iteratively as data quality and system functionality improved.

It was resolved that the Committee:

- **NOTED** the report; and
- **AGREED ACTION:** future updates include clearer milestones, delivery trajectories and assurance routes.

AC26.32 Standards of Business Conduct

The Head of Corporate Governance presented the report. Members challenged whether current Declarations of Interest reporting adequately reflected organisational risk, particularly in relation to staff holding delegated authority for contracting or expenditure. Concerns were raised regarding the clarity of data presented and the potential for confusion between non-declaration and nil declaration.

Discussion focused on the need to adopt a risk-based approach to assurance, prioritising roles with decision-making authority rather than relying solely on aggregate compliance figures. Officers advised that work was underway to improve systems and processes, including alignment with appraisal processes and procurement controls.

It was resolved that the Committee:

- **NOTED** the report; and
- **AGREED ACTION** that future assurance should adopt a more explicit risk-based focus and clarification would be received regarding the figures provided within the report.

AC26.33 Statutory Compliance Report

The Head of Statutory Compliance and Inquiries presented the report. Members expressed ongoing concern regarding overdue policies and the quality and timeliness of evidence submitted to support audit recommendation closure. The Committee noted that a revised policy management process had been developed and consulted upon, and that governance arrangements for policy oversight continued to represent a significant area of risk.

The Committee also considered the proposed closure of a number of internal audit recommendations and discussed the importance of ensuring that closure decisions were supported by robust and verifiable evidence.

It was resolved that the Committee:

- **NOTED** the Statutory Compliance report; and
- **APPROVED** the closure of internal audit recommendations as detailed within the report.

AC26.34 Corporate Governance Code

The Head of Corporate Governance presented the annual assessment of compliance with the Code of Corporate Governance. Members noted that the assessment would inform the Annual Governance Statement and acknowledged the importance of ensuring that reported compliance was reflected in practice.

It was resolved that the Committee:

- **AGREED** the assessment of compliance and intention to reflect within the Accountability report.

AC26.35 Update on draft Annual Accounts 2025/26

The Executive Director of Finance provided an update on progress with preparation of the 2025/26 annual accounts. He advised that accounts preparation was on track for statutory submission, with Audit Wales fieldwork scheduled to commence in early May. Members welcomed the progress made and acknowledged improvements in financial control and reporting disciplines.

It was resolved that the Committee:

- **NOTED** the update.

AC26.36 Internal Audit Progress Report, Internal Audit Plan, Mandate and Charter 2026/27

The Head and Deputy Head of Internal Audit presented the progress report highlighting **continued improvement in assurance ratings**, including the first **Substantial Assurance** opinion for some time. The Committee acknowledged this as a significant achievement and credited operational teams for improved controls and compliance.

It was noted that:

- The **management response rate** to internal audit recommendations had improved (from 57% to 62%), although concerns remained regarding late or missing responses.
- A number of audits were complete, with others in draft or work in progress. Some audits would report into the next audit year due to timing and data issues.
- Four of seven follow-up recommendations relating to capital projects had been closed.

In respect of the individual final audit reports the following was noted :

Tehmeena Ajmal, Chief Operating Officer, joined the meeting to participate in discussion of the **On-Call Arrangements** Internal Audit report.

The Committee discussed the **limited assurance** opinion and noted

- Ongoing pressures on gold and silver on-call rotas.
- Inconsistencies in job descriptions and contractual expectations.
- Training gaps, particularly for executive directors undertaking gold on-call roles.

The Chief Operating Officer described actions underway, including:

- Review of job descriptions through “Foundations for the Future”.
- Expanded training and support for on-call roles.
- Improved learning and feedback following incidents.

The report was noted.

ACTION AGREED : The Committee requested **further assurance updates at 6 and 12 months** on progress in strengthening on-call arrangements.

Clara Day Executive Medical Director joined the meeting to participate in discussion of the **NICE Guidance Compliance** Internal Audit report.

The Committee discussed the **reasonable assurance** opinion and noted:

- Strong controls in relation to NICE Technology Appraisals for medicines.

- Weaknesses in compliance with NICE clinical guidance, including the ability for staff to bypass systems without appropriate justification and limited senior oversight.
- Increasing challenges where NICE recommendations are not financially or operationally deliverable.

The Executive Medical Director outlined new processes to:

- Identify and scrutinise areas of non-compliance or partial compliance.
- Consider compliance at a whole-system level rather than in isolated services.
- Use derogations with clear mitigations where full compliance is not achievable.

The Committee welcomed the strengthened governance approach and highlighted the need for clearer reporting and assurance.

The report was noted.

Tehmeena Ajmal and Clara Day left the meeting

Risk Management and Board Assurance Framework Internal Audit report

The report received a **reasonable assurance** opinion. The Committee noted:

- Improvements in the Health Board's approach to risk management.
- Ongoing issues with linking gaps in controls to actions within the Corporate Risk Register.
- A high number of overdue risks and low compliance with risk awareness training.

It was reported that a new risk register template had been introduced to address these weaknesses.

The report was noted.

Culture and Leadership Internal Audit report

The audit received a **reasonable assurance** opinion. The Committee noted this was a broadly positive report, with assurance that plans were in place to deliver Integrated Medium Term Plan (IMTP) priorities, although some evidence and reporting to committees required improvement.

The report was noted without further comment.

Statutory Compliance - Asbestos Management Internal Audit report

The Committee noted the **substantial assurance** opinion and welcomed the significant improvement following previous weaker ratings. This was recognised as a strong example of effective operational improvement and compliance with statutory requirements. The Director of Estates and Environment commended the Estates team for the improvements achieved.

The report was noted and commendation recorded.

Internal Audit Plan 2026–27

The draft Internal Audit Plan for 2026–27 was presented. Key points noted:

- The plan is risk-based, aligned to the Board Assurance Framework and IMTP priorities.
- Specific focus on **Foundations for the Future**, financial sustainability, project delivery, and ministerial directives.
- Concerns were raised regarding assurance over:
 - Zero-based budgeting readiness for 2027–28.
 - Shift towards primary and community care and partnership working.
- Member concerns were also reiterated regarding delays and non-engagement in management responses.



Management acknowledged these gaps and advised that further clarity was required on governance arrangements before internal audit could provide assurance in some areas. The Committee requested the plan be kept under review as organisational priorities and programmes mature.

The Head of Internal Audit advised of a forthcoming internal audit staffing gap, however the recruitment process was underway to secure another team member.

It was resolved that the Committee:

- **NOTED** the progress report and raised concerns regarding late management responses.
- **APPROVED** the **Internal Audit Plan, Mandate and Charter for 2026–27**, subject to review later in the year should priorities change.

AC26.37 Audit Wales: Update to BCUHB Audit Committee

Audit Wales provided an update on progress against the financial and performance external audit work programmes.

Key points noted:

- **Financial audit (2025–26 accounts):**
 - Audit work is scheduled to commence on 5 May 2026, continuing through to June 2026.
 - Audit Wales expressed confidence that the audit should complete in advance of the statutory deadline of 30 June, subject to timely availability of information and management support.
 - Early planning work has also begun in relation to Charitable Funds, with fieldwork ongoing.
- **Performance audit work:**
- The Structured Assessment report has been cleared and its final version was issued to the Health Board.
- The Strategic Financial Assistance review is in clearance and will be available for the next meeting of the Audit Committee.
- The Quality Governance review is also nearing completion, pending final factual accuracy checks.
- A deep dive on digital systems is at draft stage.
- Estates and corporate services audit work is currently at the fieldwork stage and progressing as planned.
- Some reports were not ready for this meeting but would be presented to the next Audit Committee.
- **National publications and wider learning:**
 - The Additional Learning Needs national review was published earlier in the month.
 - The Managing the Regional Integration Fund (RIF) report was published in the previous month.
 - Audit Wales' Annual Plan for Wales has since been published, outlining priority areas for the coming years.

Discussion:



- Members discussed the Regional Integration Fund review and noted that it built on previous work commissioned by Welsh Government, including links to earlier urgent and emergency care audits.
- Concern was raised regarding the findings of the Additional Learning Needs review, particularly around health inequalities and premature mortality for people with additional learning needs.
- Members agreed that such national reports should act as a trigger for local reflection and action, rather than being simply noted.

Assurance:

- Audit Wales confirmed that some organisations had undertaken patient-story deep dives or follow-up discussions in response to similar findings.

It was resolved that the Committee:

- **NOTED** the report
- **AGREED ACTION** to itemise within the Committee forward work plan to consider the implications of the Additional Learning Needs review in approximately six months, and whether further scrutiny or assurance work is required locally.

AC26.38 Audit Wales: BCUHB Structured Assessment 2025 report

Key points:

- The report provided a comprehensive assessment of governance, financial management and organisational effectiveness.
- Members noted the importance of developing a clear and structured response to the recommendations.
- It was highlighted that detailed prior consideration by the Audit Committee should inform subsequent discussion at Board level.

Assurance:

- Audit Wales confirmed that:
 - Financial statements **received an unqualified audit opinion**.
 - Performance audit reports, including Planned Care and Urgent and Emergency Care, had already been considered earlier in the year.
 - The Structured Assessment summary largely draws together conclusions previously reported.

It was resolved that the Committee:

- **NOTED** the report
- **AGREED ACTION** to liaise with Audit Wales to ensure a co-ordinated response to the Structured Assessment recommendations is brought to Audit Committee prior to Board consideration in future timetables (Cycle of Business).

AC26.39 Audit Wales: Draft Annual Audit Summary Report 2025–26

The Committee considered the Draft Annual Audit Summary Report.

Discussion:

- Members welcomed the proposal to publish Annual Audit Committee Assurance (AAA) reports within a short timeframe following meetings.
- The Head of Corporate Governance confirmed:
 - Publication commenced from 1 April.



- The first report has already been published.
- The aim is publication within seven days, subject to Chair sign-off.

Assurance:

- Accountability agreements were confirmed to be progressing, with the majority already signed and issued.

It was resolved that the Committee:

- **NOTED** the report.

AC26.40 Audit Wales: Draft Annual Audit Plan 2026–27

Key points highlighted by Audit Wales:

- Accounts were expected to be received on 30 May.
- Key audit risks identified included:
 - Risk of misstatement in expenditure and journal entries, particularly given forecast deficit pressures.
 - Capital expenditure underspend earlier in the year, with a concentration of spend late in the financial year.
 - Failure to meet the three-year financial duty, which will result in a qualified regulatory opinion.

Discussion:

- Members recognised the scale of the financial challenge but noted that the forecast deficit represented a relatively small proportion of overall turnover.
- Senior officers highlighted:
 - Strong improvements in financial governance over recent years.
 - Timely submission of accounts with no changes between draft and final versions.
 - A continued need to strengthen capital planning to reduce end-year delivery risks.

Assurance:

- The Committee acknowledged the high level of accuracy required by the audit materiality thresholds.
- Positive assurance was provided regarding the capability and performance of the finance team.

It was resolved that the Committee:

- **NOTED** the report and confirmed it was content with the proposed approach.

AC26.41 Counter Fraud Progress Report and Work Plan

The Head of Local Counter Fraud presented the Counter Fraud Progress Report and proposed work plan for 2026/27.

Members noted ongoing prevention activity, case management and engagement with staff, and welcomed the continued focus on fraud risk.

It was resolved that the Committee:

- **NOTED** the progress report; and
- **APPROVED** the Counter Fraud Work Plan for 2026/27.

AC26.42 Agree items for referral to Board/other Committees



The Committee considered key themes for inclusion within the AAA report to the Health Board arising from the meeting which included the pace and consistency of audit recommendation closure, the need for clearer governance and milestones for major programmes, improving assurance over declarations of interest through a risk-based approach, and strengthening committee oversight arrangements.

The Committee Chair emphasised the need for the organisation to implement a strongly articulated risk-based governance framework which provided clarity on scrutiny through Committees to the Health Board so that Members could have confidence in the Health Board's assurance processes.

AC26.43 Review of Meeting Effectiveness

Members reflected on the following

- Improvements were needed on report submissions to the deadlines requested.
- Effective assurance reporting was required in order to provide sufficient Member confidence that the Committee's work remained at strategic level and not operational.
- Timelines and end of year targets needed to be clearly articulated and understood by members. It was important that *"in order to know the destination, the journey had to be understood"*.
- Attention was drawn to the role of the maturing Executive Delivery Groups which would provide improved line of sight to the Executive Committee.

AC26.44 Date of the next meeting : 23.6.26

Resolution to exclude the Press and Public

"representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."



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Audit Committee Action Log (Public)

Updated 11.8.26

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
REMAIN OPEN						
1	AC26.66	26.6.26	Financial Annual Accounts 2025/26 Agreed that a high-level recovery plan overview (to include impacts and timelines) be provided to the next Audit Committee (August)	Executive Director Finance	August 2026	Propose to transfer The Savings Plan is in progress and has been discussed by the Financial Oversight Group and progress to be reported to the Board in September 2026
2	AC26.67	26.6.26	Draft Annual Report 2025/26 Action: Future complaints performance reports to include forward-looking trajectories and forecasts, benchmarking against comparable organisations, and enhanced analysis of complaint trends, themes, causes and emerging risks to support strategic oversight.	Director of Performance	December 2026	Propose to transfer For progress to be considered via the Performance, Finance and Information Governance Committee
3	AC26.68	26.6.26	Head of Internal Audit (IA) Opinion & Annual Report 2025/26 Action: Consider digital governance oversight, structures and reporting arrangements at a future Committee	Interim Chief Digital Information Officer	October 2026	In progress The Digital Data Review will report through to Audit Committee in due course

			meeting.			
4	AC26.70	26.6.26	Audit Wales progress report Strategic Funding @letter Action: Chief Executive to provide a formal management response addressing the issues raised by the Committee.	Chief Executive	August 2026	Completed See Appendix 1 attached – letter from Chief Executive to Audit Wales 4.8.26
5	AC26.32	23.4.26	Standards of Business Conduct Action: Enhance Declarations of Interest reporting to provide risk-based assurance and clearer analysis of declaration compliance.	Head of Corporate Governance	October 2026	In Progress Report in October to show improved reporting framework
6	AC26.36	23.4.26	Internal Audit Progress Report Action: Future reports to provide six and twelve-month assurance updates on the implementation and effectiveness of improvements to on-call arrangements.		October 2026 April 2027	Remain Open Recommend assurance is provided from People and Culture Committee and include as specific agenda items (to be added to the work plan if agreed).
7	QS26.38.2	0	Transferred action from QSEC: Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	Executive Director Nursing and Midwifery	October 2026	Remain Open Entered on workplan
8	AC26.4.2	17.2.26	Matters arising Address realistic timing of when the Committee actions are due via the Chairs Advisory Group	Director of Corporate Governance		Remain open 09.04.26 This will be added to the 2.6.26 agenda for CAG where it was agreed to develop a short protocol. This is in draft and has been shared with Committee Chairs
9	AC25/136.1	21.10.25	Statutory Compliance Report	Pam Wenger	Feb 26	Remain Open

			A copy of the documentation in relation to the Major Project Governance and Contractor Management Review to be shared at the next meeting in December 2025.	Russell Caldicott	April 2026	09.4.26 This is scheduled to be on the agenda 17.2.26 Concern was raised on the delay to presentation of the report however assurance was provided that it would be presented to the next meeting. 10.2.26 The Report is in the process of being finalised and will be brought through to the next meeting. 1.12.25 Chief Executive confirmed at the Board meeting on 27.11.25 that the Commissioning Assurance Framework was in draft.
10	AC24/151.1	05.11.24	Centre for Mental Health and Society (CfMHaS) (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.	Pam Wenger Russell Caldicott	March 25 May 25 Revised timescale August 26	Remain Open 6.7.26 – Agenda item August meeting 09.04.26 This item will be received at the next Audit Committee. An explanation has/will be shared outside of the meeting. 10.3.26 Public session agenda item 21.4.26 09.02.26 On the private agenda for 17.02.26. 27.01.26 Draft internal audit report has been issued to the Health Board for consideration. A



						meeting is being planned to discuss the findings with key officers. =27.11.25 Audit in progress update to be provided by Head of Internal Audit. 11.09.25 An update has been provided in the Corporate Governance Report. The procurement of an independent reviewer has been completed and the evaluation report is anticipated to be available for the next meeting in December 2025. 27.07.25 An extended deadline of 10 July 2025 was provided and the Health Board has received two expressions of interest. The Corporate Governance Directorate will now progress this in partnership with the Procurement Team with work estimated to commence during August 2025 with an update to Audit Committee planned for October 2025. 09.05.25 An independent reviewer has been sought on the procurement portal (since 14.03.25). Currently awaiting expressions of interest to



						complete the work. A report is due to go to the Committee in June 25 dependant on securing an independent reviewer. 04.03.25 In relation to the Centre for Mental Health it has been agreed to commission a review and this will come back to Committee. 03.02.25 ToR have now been drafted and awaiting final review before procurement in February 2025. A full evaluation report is due to be presented to the Committee in April 25 (subject to procurement) 08.01.25 An evaluation of the CfMHaS Agreement will be commissioned and the final report will be brought to the Committee once received. The terms of reference for the review are currently being finalised in order that procurement for the review can be commissioned.
11	AC25/32.1	04.03.25	Information Governance and Records Management Position The Executive Committee to take some time to consider the matter, identify best practice, clarify that the risk is logged and bring the item	~~Pam Wenger~~ ~~Dylan Roberts~~ Justine Parry	~~Oct 25~~ Revised timescale Apr 26	Remain Open 12.3.26 JP advises: No progress to date due to staffing resource issues – to be considered through Executive Committee prior to submission when resource



			back to the Committee.			available to progress. 17.2.26 Noted due to be presented at the next meeting 11.09.25 The PFIG Committee received an update on Information Governance and Records Management at their meeting on 26.08.25 - please see link below to the paper and note item PF25.74 Information Governance: PFIG Agenda Bundle 26.08.25 This requires further discussion with the DDaT Team. 29.07.25 A session on records management to take place with the Executive Committee and this will be included on the agenda for a more substantive item at a future meeting. 19.03.25 Dylan Roberts to discuss with Carol Shillabeer and agree how the corporate records management function will be resourced. A paper will be presented to the Executive Committee and come back to a future meeting of the Audit Committee.
ACTIONS PROPOSED FOR CLOSURE						
1	AC26.68	26.6.26	Head of Internal Audit (IA) Opinion & Annual Report 2025/26	Chief Executive	August 2026	Propose to close E-mail sent to all Executive Team

			Action: Chief Executive to reinforce expectations regarding the timely response to complaints and correspondence by Executive Team members, and to issue a communication to Executive colleagues accordingly.			Members (agreed with the Head of Internal Audit). Issues of timeliness are escalated to the CEO on a weekly basis by the Director of Corporate Governance
2	AC25/136.2	21.10.25	Statutory Compliance Report Director of Corporate Governance to follow up the progress in relation to the implementation of a Commissioning Assurance Framework outside of the meeting and report back to the Committee.	Russell Caldicott	Feb 26 April 2026	Propose closure 28.5.26 CAF presented to Board 21.04.26 The Executive Director of Finance and officers advised that delays had arisen due to portfolio changes following the departure of the Director of Performance and Commissioning, with responsibility subsequently transferring into the Finance portfolio. Updated timelines were provided, including confirmation that the Commissioning Assurance Framework was scheduled for consideration by the Executive Committee on 6 May, followed by Board consideration later in May. 09.04.26 This is scheduled to go to be considered at PFIGC and then to Board. 10.3.26 This is scheduled to be dealt with by the Performance, Finance and Information



						Governance Committee (PFIGC). 17.2.26 Concern was raised on the delay to presentation of the report however assurance was provided that it would be presented to the next meeting. 10.2.26 This now falls under the remit of the Executive Director of Finance. The document is in draft and being worked through by the Executive Lead. 1.12.25 Chief Executive confirmed at the Board meeting on 27.11.2025 that the Commissioning Assurance Framework was in draft.
3	AC26.10.1	17.2.26	Corporate Risk Register (CRR) Staff stress related sickness should also capture and report on 'work related' sickness within future reporting.	Executive Director People Services & OD	August 2026	Propose to close 11.8.26 The Corporate Risk Team is supporting the Risk Lead to revise the Corporate Risk Register entry following a risk deep dive. The updated entry will be included in the next CRR update. 9.3.26 Jody Evans informs this is being written into the CRR update by the responsible lead.
4	AC26.32	23.4.26	Corporate Governance Improvement Programme Action: Enhance the Corporate Governance Improvement Programme reporting framework to	Head of Corporate Governance	August 2026	Propose to close Agenda item Corporate Governance report- August Meeting.

			include interim milestones, measurable indicators of progress and clear evidence of improvement throughout the year, with particular focus on overdue policies and Board effectiveness.			
5	AC26.30	23.4.26	Update on Outstanding Audit Recommendations – EDoF Action: Future updates to focus on evidencing delivery of sustained improvements in oversight and control, with clear milestones, governance routes and appropriately timed internal audit follow-up to provide meaningful assurance on implementation.	Head of Statutory Compliance	August 2026	Propose to close
6	AC26.68	26.6.26	Head of Internal Audit (IA) Opinion & Annual Report 2025/26 Action: Director of Corporate Governance to provide a breakdown of complaint response rates by Executive portfolio to support Committee scrutiny and oversight.	Director of Corporate Governance	August 2026	Propose to close The Director of Corporate Governance has received the information from the Head of Internal Audit and shared with the Audit Committee Chair separately
7	AC25.167	17.12.25	Internal Audit Progress Report The Head of Internal Audit to follow up the Learning – Regulatory Reporting (BCU-2526-11) report with the Director of Corporate Governance and re-present to the Committee at a future date.	Head of Internal Audit	May 26	21.4.26 Agreed to close A review will be undertaken as included within Quarter 1 of the 2027/28 internal audit work plan 17.2.26 Remain open 27.1.26 The five agreed management actions have two key milestones



						for implementation, 31 March 2026 and 31 March 2027 respectively. The key governance action is set for 31 March 2027 implementation; any review prior to this would not capture the required governance arrangements being in place. Subject to Audit Committee approval, a review will be undertaken in Quarter 1 of the 2027/28 internal audit plan.

Closed Actions (as agreed at meeting on 21.4.26)

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	AC26.6.1	17.2.26	Statutory Compliance Report Share with members updates for Ysbyty Gwynedd Emergency Department (ED) actions and Ombudsman deadlines.	Director of Corporate Governance	20.3.26	Agreed closed on 21.4.26 9.3.26 Circulated information, prepared by Glesni Driver, to members via email
2	AC26.4.1	17.2.26	Matters arising Arrange to advise the Ombudsman of delay to implementation of the Commissioning Framework.	Executive Director of Finance	20.3.26	Agreed closed on 21.4.26 The Ombudsman has been made aware of the delay to implementation.



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Bloc 5, Llys Carlton, Parc Busnes Llanelwy,
Llanelwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business
Park, St Asaph, LL17 0JG

Andrew Doughton,
Performance Audit Manager,
Audit Wales,
1 Capital Quarter,
Cardiff,
CF10 4BZ

Ein cyf / Our ref: CS/AW/CE26/0364

Eich Cyf/Your Ref: PA346/AD/hcj

Ffôn: 01745 448788 ext 6382

Gofynnwch am / Ask for: Emma Hughes

E-bost / Email: emma.hughes19@wales.nhs.uk

Dyddiad / Date: 4th August 2026

Dear Andrew,

RE: Use of Welsh Government strategic financial allocation 2020-2025

I would firstly offer my thanks to you and the team for the work undertaken on the use of Strategic Funding for Betsi Cadwaladr University Health Board. I understand the considerable interest in how the health board over the last 6 years has utilised this funding for the benefit of patients. As you are aware the funding was made available to the health board late in 2020 as the organisation was de-escalated to Targeted Intervention. The report clearly articulates almost 50% of the funding received over the six financial years related to a deficit between income and expenditure of £40m per annum, with the remainder to be utilised in key capacity building and transformation areas.

The balance of £42m per annum was utilised in supporting Transformation and Service Improvement committed historically by the previous leadership of the Health Board, and during exit of Covid. Unfortunately, we have not been able to evidence the impact tracking that may have been expected to be required at the time. As a consequence, whilst it is clear where funding has been deployed, the relative benefits realised historically by the Health Board are difficult to quantify.

I would also like to place on record my thanks for the recognition of the increased visibility, and robustness of the prioritisation process enacted by the Health Board in seeking to align the funds to transformation and service improvement during mine and the current Boards oversight. In relation to each of your points requiring clarification on next steps by the Health Board I would state;

Question 1 & 2 - Plans to describe how the Strategic Funds have been used and benefits and provision of prospective updates on use to relevant Committees;

As articulated already, c50% of the allocated funds use is clear, with this offsetting a financial deficit within the Health Board, and whilst clear on how the remaining £42m per annum was allocated, benefits realised are more subjective with senior leaders taking these decisions having now left the Health Board. For these reasons I agree it is difficult

Cyfeiriad Gohebiaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive:
Swyddfa'r Gweithredwyr / Executives' Office
Ysbyty Gwynedd, Penrhosgarnedd
Bangor, Gwynedd LL57 2PW

Gwefan: www.pbc.cymru.nhs.uk / **Web:** www.bcu.wales.nhs.uk

Mae Swyddfa'r Prif Weithredwr yn croesawu gohebiaeth yn Gymraeg a bydd yn sicrhau y darperir ymateb yn Gymraeg heb oedi.
The Chief Executive's Office welcomes correspondence through the medium of Welsh and will ensure that a response is provided in Welsh without incurring a delay

to articulate benefits historically delivered through use of the element associated with the Strategic Fund.

Over the last 2 years however, as a health board we have undertaken review processes led by the Planning and Transformation Directorate of the Health Board and aligned to the Integrated Medium Term Planning approach. This continues to play an active role in oversight and prioritisation, monitoring the ongoing use of the fund and increasingly seeking to measure future benefits. The visibility of these (which can be shared with Audit Wales colleagues in subsequent reviews on use) will be reported through Executive and onwards to the Performance, Finance and Information Governance Committee.

Question 3 - The Health Board continued receipt of the £42m is contingent on delivery of financial balance, what arrangements are in place to mitigate the risk of the funding no longer being received;

The Health Board has £82m contingent on delivery of financial balance and exiting of 'Special Measures' with £40m to support a historic deficit and £42m per annum transformation and Improvement. It is therefore imperative in the formation of future plans and for future stability and sustainability for these funds to remain with the Health Board.

To ensure financial balance is achieved (the key financial duty attained) the Health Board has allocated savings targets to the business units and further deployed the national model for Improvement of 'Value & Sustainability'. The deployment of these measures has resulted in continued improvement in financial performance, with the target being for 2026/27 to deliver a stretch savings target of £63m and 2.4% of baseline.

The Health Board's Performance, Finance and Information Governance Committee provide oversight on financial delivery (Audit Committee oversight on Statutory duty to breakeven over three financial years). The Executive, Integrated Performance – Executive Delivery Group and Financial Oversight Group (Chaired by the Chair of the Health Board) actively reviews assurances over the delivery of financial balance.

The Health Board has set clear timeframes for identification of savings by Directorate and Area, on Value & Sustainability with lead Executives and further is developing a number of 'choices' that the Board can consider to achieve breakeven.

The Health Board (in delivery of break-even) will secure the £82m Strategic Funds and also for 2026/27 mitigation of increased costs totalling £26m for the Welsh Risk Pool. In summary, £108m of resource or mitigations are reliant on attainment of break-even and if this funding is withdrawn significant decisions on reduction/cessation of services and/or back office functions will be required.

I am clear, and will advise the Board, that the risk of not securing the funding on an ongoing basis presents a highly significant challenge to the progress that has been made in the organisation over the last 3 years. This is because whilst the health board had improved across a broad range of areas since escalation to Special Measures/Level 5 in



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February 2023, there continues to be more work needed to fully embed and sustain the long-lasting changes that the Board and the public wish to see.

I would conclude by thanking you once more for your report on allocation for use of the Strategic Fund, and for your recognition of the progress made in prioritisation of the use of the fund and further deployment of the resources that for future reporting will enable modelling of benefits realisation.

Kind regards,

A handwritten signature in dark ink, appearing to read 'Carol Shillabeer'.

Carol Shillabeer
Prif Weithredwr/Chief Executive

Audit Committee

Director of Corporate Governance update presentation on Open Audit Recommendations and Corporate and Board Assurance Framework Risks



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18th August 2026

Limited Audit Reports presented:

Report Title / Objective(s)	Year	Total number of report findings	Number limited assurance findings	Number of limited findings implemented / complete	Total number of limited findings open
Learning – Regulatory Reporting	2025	6	6	1 implemented, going through closure process	5
Executive Committee: Governance	2026	4	4	0	4
Standards of Business Conduct	2026	6	4	0	4



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Learning – Regulatory Reporting

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Register of regulators/statutory bodies - Regulator Relationship Management Matrix being updated to capture all regulators, statutory and professional bodies, current relationship, processes associated with their publications, and the monitoring and reporting arrangements. Governance and Regulatory EDG - Meeting dates diarised on a bi-monthly basis, with the first meeting held on 07/07/2026 - Terms of Reference updated to capture membership, and reviewed at the first meeting - Executives have identified areas for prioritised focus over the next 6-12 months to ensure appropriate governance, assurance and relationship management arrangements are in place - The Regulatory Relationship Management Matrix will be used as the primary mechanism for oversight of external regulatory and professional body relationships - The EDG will look at the current reporting arrangements at tier 2 level to ensure appropriate governance. Learning from regulatory reports - The 'Procedure for Referral to the Discovery and Learning Steering Group' approved and published and is now live on BetsiNet. Corporate procedure - Work on procedure will commence once there is clarity around the reporting and monitoring of regulatory reports	Regulatory/statutory body information - reliant on updates from across the Health Board – delayed due to competing demands/lack of resources	Additional time given to provide the information	Continued engagement with subject matter experts to source the information



Executive Committee: Governance

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Executive Committee - Standing Order Conflict - TORs reviewed and planned for EC consideration in August, the delay is due to some changes proposed to the Scheme of Delegation (now on the agenda for Audit Committee) Expected completion August Terms of Reference and supporting governance architecture - Work underway to refresh the TORs to reflect current executive structure and governance arrangements. A full mapping exercise of groups and programmes reporting into EC completed, including identification of assurance routes and gaps in reporting. A draft cycle of business aligned to EC delegated responsibilities developed, and being built into the EC forward plan. Expected completion September Established Groups reporting to EC - Review of groups/programmes within EC governance framework scope undertaken to confirm reporting lines, frequency, and purpose. A standard approach to reporting being developed to ensure key risks, decisions, financial implications, and matters requiring escalation consistently visible to EC. Expected completion September Programmes/Groups TORs - Initial review of TORs and membership completed, identifying areas of overlap with EC membership and risks of self-assurance. Discussions with executive leads underway to clarify accountability, define roles (decision-making vs advisory vs assurance), and ensure appropriate chairing arrangements, with increased delegation to executive directors. Updated ToRs and membership arrangements progressing in line with the developing EC governance framework. Expected completion September			



Standards of Business Conduct

PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/ DELIVERY	MITIGATION IN PLACE TO ENSURE DELIVERY	PLAN AND TIMELINE FOR DELIVERY
Review and escalation of non-compliance – Band 8C and above, and private practice Working on a way to triangulate the Declare system with those who are identified as budget holders, Medical or Dental workforce, once this has been resolved, escalation will take place. Gifts, hospitality and sponsored events Complete a compliance review of sponsored events, undertake targeted follow-up with individuals who have not submitted required declarations, reinforce expectations through staff communications and line management arrangements, and introduce routine monitoring to strengthen compliance and assurance	Limitations of the Declare System, and the manual process of identifying the necessary individuals	Looking at alternative ways to progress due to the limitations of Declare	Continued engagement with colleagues relating to the ESR process, and how it can easily identify the necessary individuals



Structured Assessment 2024 – open recommendations

ID	Key Finding	Management response	Update
1453	Rec 2. In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role.	Currently there is no accountability or responsibility for the Senior Leadership Team in terms of operational governance, it is a mechanism by which the Members of the Executive Team can engage to support the delivery of the Health Board plans. As part of the Foundations for the Future Programme, clarity on roles and responsibilities for groups will be confirmed alongside the role of the Senior Leadership Team and the Operational Leadership Team. Key actions include: • Review of the operational governance arrangements including the role of the Senior Leadership Team	A report received by the Executive Team on 15 July 2026 containing an Operational Governance Framework including draft Terms of Reference for Service Group Senior Leadership Teams. This will reflect work undertaken in two workshops that were undertaken with senior Service leaders (1 June 2026 and 16 June 2026) PROGRESSING THROUGH CLOSURE APPROVAL PROCESS AT PRESENT.
1456	Rec 5. The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board.	The Health Board is considering the most appropriate way to engage the wider Board in terms of visiting services. Individual Board Members visit sites on a regular basis. Key actions include: • Agree how the Board can engage with services, which will include plans in terms of service reviews; • Establish a reporting mechanism to the Board in terms of service visits	Progressing through closure approval process - Board visit areas have now been agreed, with a supporting protocol approved by the Board and visits are already underway. The remaining visits will be scheduled and delivered over the next 12 months. PROGRESSING THROUGH CLOSURE APPROVAL PROCESS AT PRESENT.
1458	Rec 6. As part of the development of a meaningful Board Assurance Framework, the Health Board should provide Board members with further supporting detail on its strategic objectives to clarify what the objectives are seeking to achieve.	The Health Board has reviewed the Board Assurance Framework during 2024/25 which will be aligned to the Strategic Objectives for the 2025/26 Plan once agreed by the Board. Action: To provide additional detail as part of the development of the IMTP for 2025/26	In line with the IMTP 2026–2029 and the four new strategic priorities, any outstanding actions from the existing BAF have been mapped to the relevant ADP deliverables and are currently awaiting linkage within the portal. The Director of Corporate Governance is currently arranging to meet with the relevant Executives to review the proposed mapping against the four revised BAF risks. These risks were presented to the Board for discussion at the May 2026 Board meeting and have subsequently been issued for consultation. The aim is to have the BAF available within the portal by July 2026. The associated actions, aligned to the IMTP 2026–2029, will be linked to the relevant ADP deliverables, which have already been incorporated into the IMTP Narrative Plan.



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Structured Assessment 2024 – open recommendations

ID	Key Finding	Management response	Update
1459	Rec 7. The Health Board should ensure that audit reports that are relevant to the remit of other Board committees are received and discussed by those committees, including periodic updates against any associated recommendations.	The Health Board is considering the approach to dealing with reports from external regulatory bodies as part of the IMTP for 2025/26. However, there has been progress during 2024/25 which has included progress against external audits at committees, and it recognises there is more to do in this area. Action: The governance process on reviewing of audit reports will be developed further to ensure that audit reports are considered at the relevant committees as well as Audit Committee.	Audit reports are considered by the appropriate committee, eg, Job Planning, Clinical Audit reported to the QSE Committee; Operating Model audit report reported directly to Board and through the People and Culture Committee; Health and Safety audit report through the People and Culture Committee. All audit reports are also presented to the Audit Committee. PROPOSE TO CLOSE



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Structured Assessment 2025 – open recommendations

ID	Key Finding	Management response	Update
1798	Rec 3 The Health Board should increase the pace of its process to update high-risk policies.	The Health Board has made progress on reducing the number of overdue policies. The Health Board will aim to eliminate the number of high-risk policies by end 2027 (with the exception of All Wales Policies) aligned to the improvement in policies processes.	There continues to be a number of overdue policies, including those linked to patient safety, and progress is inconsistent across portfolios, with uneven delivery. However, there is continued and targeted focus on high-risk (patient safety) policies, with progress reporting to Executive Committee and Audit Committee on a bi-monthly basis (in line with Audit Committee reporting requirements).
1803	Rec 6 The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports).	Lead Executives will be identified for attendance at meetings where there is a specific report being presented that requires their input.	Executives are invited to all Committees where their relevant internal audit reports are discussed



Structured Assessment 2025 – open recommendations

ID	Key Finding	Management response	Update
1804	Rec 7 The Health Board should ensure that it has the appropriate programme management and governance arrangements in place to support the roll out of the Foundations for the Future Programme. Specifically, it needs to ensure that: 7.1 It has sufficient management capacity to support the timely roll out of the Programme. 7.2 All Executive Team members are appropriately sighted of, and aligned with, the changes that the Programme intends to bring about. 7.3 Independent Members are appropriately briefed on the Programme and have sufficient opportunity to seek the assurances they need on its implementation.	The Health Board has received reports on progress against the Foundations for the Future Programme; the frequency and regularity of reporting will increase as the programme moves through to the 'deliver' phase to consultation: • From March 2026 onwards management capacity will be kept aligned to programme needs through ongoing review of workstream resourcing and strengthened Programme Team support where required. • Executive alignment will be supported through an Executive review of the Programme Highlight Report and continued participation in Workstream Deep Dives. • The People and Culture Committee will receive regular reports against the delivery of the programme with additional sessions arranged for the full board as necessary. • Staff engagement will continue through the Programme's Communications Plan and dedicated intranet pages that provide accessible, up-to -date information.	Programme reporting and governance improvements: • Regular review of delivery assurance • Review of programme-level and product level risks Management capacity and programme resourcing: • Resource risks continue to be identified and monitored at programme and workstream level, and escalated through governance. Executive alignment and oversight: • Regular Executive Team engagement and input on key areas • Updates to Executive Committee, Informal Board, Escalation Board and WG forums • Executive participation in Programme Board and Workstream Deep Dives Committee and Board reporting: • Regular reporting to People and Culture Committee, including escalation of key risks and resourcing needs • Additional engagement via LPF, Informal Board and other governance groups Staff engagement and communications: • Updated communications plan, including FAQs, FFTF Hub, consultation support • Ongoing culture and workforce initiatives



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Structured Assessment 2025 – open recommendations

ID	Key Finding	Management response	Update
1805	Rec 8 The Health Board should strengthen budget-setting approach to move away from the current position of rolling over existing budgets to one that is more zero based and reflects priorities and transformation needs in different parts of the organisation along with a more intelligence driven approach to savings planning.	In 2025-26, an incremental budget setting approach was utilised, establishment costs and cost pressures (current and future) with developments aligned to available resource. Budgets to deliver services able to be re-configured within this process and amended throughout the financial year. The Health Board will deploy a zero-based budget setting methodology for 2027-28, which whilst time consuming will require every cost to be justified and aligned to delivery priorities. However, successful delivery will require a level of further maturity from budget holders combined with clear strategies to be in place to guide prioritisation of resource (Clinical and Estate) and clear lines of delegation and accountability. The Value & Sustainability programme of works will drive improvement, combined with benchmarking of services. The total financial benefits then analysed over the IMTP three financial years to remove the underlying deficit, strengthening future savings attainment and allowing application of allocative efficiency.	Indicative savings targets to be issued in October for the next financial year, savings plans requiring development throughout the financial year and for the next financial year in advance of commencement of the new financial year. Continued reporting of savings performance through Value & Sustainability for the current and future years, this a key measure of delivery under the new Performance and Accountability Framework for areas and directorates and used to assess delivery within their performance reviews. Performance reported monthly on savings delivery within the governance forums articulated within the management response. Defined criteria for the implementation of formal recovery plans where there is overspend. Escalation through the governance forums referenced within the management response.



Corporate Risks / Board Assurance Risks

[illegible]

Audit Committee

DIWEDDARIAD AR Y COFRESTR RISG GORFFORAETHOL UPDATE ON THE CORPORATE RISK REGISTER

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Jody Evans, Assistant Head of Risk Management Anthony Hughes, Risk Assurance Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol Executive Summary

This report provides Audit Committee with assurance regarding the effectiveness of the Health Board's corporate risk management, governance and oversight arrangements.

During the reporting period, all Corporate Risks have been reviewed through a revised Corporate Risk Register framework and have been subject to scrutiny through the Risk Scrutiny Group, Executive Committee, Executive-led Deep Dive sessions and the relevant Board Committees. These arrangements have strengthened the consistency and quality of risk reporting, improved Executive challenge and enhanced the identification of controls, assurance gaps and mitigating actions.

The review process demonstrates that Corporate Risks are actively monitored, challenged and escalated through established governance structures, with clear Executive ownership and Board Committee oversight arrangements in place. Risks that remain above the Board's agreed risk appetite continue to be subject to scrutiny through the appropriate governance forums, with additional challenge being directed through Executive Committee where further assurance is required.

The principal assurance gained during this reporting cycle relates to the continued strengthening of the governance framework supporting risk management. Evidence demonstrates that risks are routinely reviewed, challenged and escalated through the appropriate governance structures and that opportunities to strengthen controls, assurance and risk reporting are being identified and addressed.

Whilst these arrangements provide increasing assurance regarding the effectiveness of governance and oversight processes, evidence of measurable risk reduction remains variable. Nine of the eleven Corporate Risks remain above the Health Board's agreed risk appetite, indicating that further work is required to demonstrate the effectiveness of mitigating actions in reducing overall risk exposure.

Audit Committee can therefore take reasonable assurance regarding the effectiveness of the governance and risk oversight framework, whilst recognising that assurance regarding the effectiveness of mitigating actions in reducing strategic risk exposure remains moderate.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Health Board	30/07/2026	Full Corporate Risk Register
Executive Committee	15/07/2026	Full Corporate Risk Register Review
Executive Committee	17/06/2026	Full Corporate Risk Register Review
- People and Culture Committee - Performance, Finance and Information Governance Committee - Quality, Safety and Experience Committee - Planning, Population Health and Partnership Committee	June and July Cycle	Risks reported to relevant Committee.
Informal Executive Committee	27/05/2026	Deep Dives: - CRR25-02 Future Demand & Sustainable Workforce - CRR25-07 Leadership and Operating Model
Executive Committee	20/05/2026	Full Corporate Risk Register Review
Risk Scrutiny Group	12/05/2026	Further minor amendments to template agreed.

Informal Executive Committee	15/04/2026	Deep Dives: - CRR25-11 Cyber & ICT Failure - CRR25-04 Modernising Infrastructure
Informal Executive Committee	01/04/2026	Deep Dives: - CRR25-06 Value Delivery & Financial Sustainability - CRR25-01 Timely Patient Access to Safe and Effective Care - CRR25-03 Population Needs
Informal Executive Committee	18/03/2026	Deep Dive: CRR25-08 Non-Compliance with Regulatory and Legislative Requirements
Acronymau / Rhestr Termau Acronyms / Glossary of Terms		
CRR	Corporate Risk Register	
RSG	Risk Scrutiny Group	
BAF	Board Assurance Framework	

DIWEDDARIAD AR Y COFRESTR RISG GORFFORAETHOL UPDATE ON THE CORPORATE RISK REGISTER

1. Y SEFYLLFA SITUATION

The purpose of this report is to provide Audit Committee with assurance regarding the effectiveness of the Health Board's arrangements for the identification, management, scrutiny and escalation of Corporate Risks.

The report sets out how Corporate Risks are overseen through the governance framework, the assurances derived from Executive and Committee scrutiny and the extent to which those arrangements provide confidence that strategic risks are being effectively managed and appropriately escalated.

The Corporate Risk Register remains a key component of the Board Assurance Framework and supports the Health Board in understanding, monitoring and responding to the principal risks that may impact delivery of its strategic objectives.

2. Y CEFNDIR BACKGROUND

Significant work has been undertaken during 2026/27 to strengthen the Health Board's approach to corporate risk management and the quality of assurance available to Committees and the Board. This has included:

- implementation of a revised Corporate Risk Register template
- improved articulation of controls, assurances and assurance gaps
- targeted Executive-led Deep Dive reviews
- enhanced scrutiny through the Risk Scrutiny Group
- clearer alignment between identified risks, mitigating actions and responsible executives
- strengthened reporting through Board Committees and Executive Committee.

All eleven Corporate Risks are now on the revised template format, providing greater consistency of reporting and strengthening the basis upon which assurance can be obtained regarding both the management of risks and the effectiveness of governance arrangements.

3. **MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

During this reporting period, all Corporate Risks have been reviewed through Executive Committee, the Risk Scrutiny Group, Executive-led Deep Dive sessions and the relevant Board Committees. This has strengthened the consistency of risk reporting and enhanced the quality of challenge, oversight and assurance available to the Board.

Review activity undertaken through the Risk Scrutiny Group identified opportunities to improve the consistency and quality of risk reporting, strengthen the alignment between assurance gaps and mitigating actions and improve the articulation of controls and intended outcomes. The revised Corporate Risk Register framework has now been implemented across all Corporate Risks and provides a stronger basis for Executive and Committee scrutiny.

Executive-led Deep Dive reviews have provided enhanced challenge across priority Corporate Risks, testing the adequacy of controls, quality of assurance, appropriateness of risk scoring and effectiveness of mitigating actions. Outputs from these reviews continue to inform refinement of risk narratives, controls and action plans.

3.1 **Corporate Risks by Theme and Assurance Position**

CRR25-01: Timely Patient Access to Safe and Effective Care

The risk continues to receive scrutiny through the Quality, Safety and Experience Committee and Executive review processes. Work remains ongoing to refine the risk structure to provide greater visibility of the key service-specific drivers contributing to overall risk exposure. This provides assurance that the risk definition and associated management arrangements continue to be actively reviewed and challenged.

CRR25-02: Future Demand and Sustainable Workforce and CRR25-07: Leadership and Operating Model

Executive-led Deep Dive reviews have identified opportunities to strengthen controls, assurance arrangements and outcome measures associated with these workforce-related risks. Further review work is being undertaken with the Executive Director of People Services and Organisational Development to ensure both risks remain appropriately defined and supported by effective mitigation plans. This provides assurance that these strategic workforce risks are receiving focused Executive scrutiny and challenge.

CRR25-03: Population Needs

The risk has been refreshed to reflect the current strategic context and the Integrated Medium-Term Plan. Ongoing scrutiny through the Planning, Population Health and Partnership Committee provides assurance that emerging population health needs and service planning risks continue to be considered through the appropriate governance arrangements.

CRR25-05: Strategic Change Impacting Care and Staff Delivery

The risk remains within the Board's agreed risk appetite. Oversight through the Planning, Population Health and Partnership Committee has identified opportunities for additional actions to support further progress towards the target risk score, providing evidence of ongoing scrutiny and challenge.

CRR25-06: Value Delivery and Financial Sustainability

The risk remains above appetite and continues to receive scrutiny through the Performance, Finance and Information Governance Committee. Review activity has focussed on ensuring that the risk reflects the current financial planning environment and that controls and mitigating actions remain aligned to the principal sources of risk.

CRR25-08: Non-Compliance with Regulatory and Legislative Requirements

This risk has demonstrated measurable improvement during the reporting period, with the residual risk score reducing from 16 to 12 following improvements in regulatory oversight, accountability and relationship management arrangements. The risk now falls within the Board's agreed risk appetite, providing evidence that governance interventions and mitigating actions can deliver measurable reductions in risk exposure.

CRR25-09: Safe Environment and CRR25-10: Health and Safety

Both risks have been reviewed to strengthen alignment between Corporate and Operational Risk management arrangements. Ongoing oversight through the Performance, Finance and Information Governance Committee provides assurance that regulatory and statutory risks continue to receive appropriate attention and challenge.

CRR25-04: Modernising Infrastructure and CRR25-11: Cyber and ICT Failure

These risks have been subject to Executive-led Deep Dive review and continue to receive oversight through the appropriate governance arrangements. Given the nature of these risks, detailed reporting continues through private governance processes where necessary.

A copy of the full Corporate Risk Register is included in Appendix 1.

3.2 Corporate Risk Profile Against Risk Appetite

Nine of the eleven Corporate Risks currently exceed the Health Board's agreed risk appetite and remain subject to ongoing oversight through Executive Committee, Board Committees and Board reporting arrangements. Two Corporate Risks, CRR25-05 and CRR25-08, are currently within appetite.

The continued position whereby the majority of Corporate Risks remain above appetite is not, in itself, evidence of ineffective risk management. Rather, it reflects the significance and complexity of the strategic challenges facing the Health Board, and reinforces the importance of continued Executive oversight, Committee scrutiny and delivery of mitigating actions.

The governance framework ensures that risks exceeding appetite are identified, monitored and subject to challenge through the appropriate governance structures. During the reporting period, the Executive Committee requested further assurance from Executive Leads regarding risk trajectories, barriers to risk reduction, appropriateness of risk scoring and the effectiveness of existing controls and mitigating actions.

Audit Committee may therefore take assurance that risks exceeding appetite are being actively monitored, challenged and escalated through established governance arrangements. However, limited movement in risk scores indicates that further work is required to demonstrate the effectiveness of mitigation activity in reducing overall strategic risk exposure.

Table 1 below shows all Corporate Risks that currently exceed the Health Board's agreed risk appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20	Quality <15
CRR25-02	Future Demand & Sustainable Workforce	Executive Director of People Services &OD	16	Quality <15
CRR25-03	Population Needs	Executive Director of Public Health	16	Quality <15
CRR25-04	Modernising Infrastructure	Chief Digital Information Officer	20	Quality <15
CRR25-06	Value Delivery and Financial Sustainability	Executive Director of Finance	20	Financial <15
CRR25-07	Leadership and Operating Model	Executive Director of People Services &OD	16	Quality <15
CRR25-09	Safe Environment	Director of Environment and Estates	20	Regulatory <15
CRR25-10	Health and Safety	Director of Environment and Estates	16	Regulatory <15
CRR25-11	Cyber & ICT Failure	Chief Digital Information Officer	20	Quality <15

3.3 Review of Risk Appetite 2026/27

The Health Board's Risk Appetite Framework is currently under review to ensure that appetite statements and tolerance levels remain aligned to the Health Board's strategic objectives, operating environment and corporate risk profile. Any proposed amendments will be progressed through the established governance arrangements for Board approval.

The current Corporate Risk profile continues to provide an important focus for Executive and Committee scrutiny. The Executive Committee has requested additional assurance from Executive Leads regarding risk trajectories, barriers to risk reduction, control effectiveness and the need for additional interventions where risks remain above appetite.

This challenge process provides assurance that the Risk Appetite Framework is being actively utilised as a governance tool to support scrutiny, escalation and decision-making. Future reporting will place increased emphasis on risk trajectory, control effectiveness and progress towards appetite levels, strengthening assurance regarding the effectiveness of risk management activity.

3.4 Delivery of Risk Mitigation Actions

A total of 115 mitigating actions are currently associated with the Corporate Risk Register. Of these, 17 actions have been completed, 96 are progressing and 2 are scheduled to commence - both actions awaiting commencement relate to CRR25-02 and are dependent upon completion of work relating to demand and capacity forecasting. Executive oversight remains in place to ensure these actions progress as planned.

Whilst action delivery remains an important indicator of progress, the primary measure of effectiveness is the extent to which mitigating actions strengthen controls, address assurance gaps and contribute to reductions in risk exposure. Review through Executive Committee and Board Committees has therefore increasingly focused on the quality and impact of mitigating actions rather than completion rates alone.

Although action plans continue to be actively managed, the continued position whereby nine Corporate Risks remain above appetite indicates that further work is required to demonstrate measurable reductions in strategic risk exposure. Future reporting will place greater emphasis on outcomes, control effectiveness and risk reduction trajectories.

3.5 Audit Committee Assurance Position

Based on the review activity undertaken during this reporting period, Audit Committee can take assurance that:

- a defined governance framework is in place for the management and oversight of Corporate Risks
- each Corporate Risk has clear Executive ownership and Board Committee oversight arrangements
- Corporate Risks are routinely reviewed through Executive Committee and relevant Board Committees
- enhanced scrutiny and challenge is being undertaken through Executive-led Deep Dive reviews
- the Risk Scrutiny Group is providing effective quality assurance and oversight of risk reporting
- assurance gaps and areas for improvement are being identified and escalated through appropriate governance arrangements
- risks that remain above appetite are subject to continued scrutiny, escalation and challenge
- improvements continue to be made to the maturity and effectiveness of the Health Board's corporate risk management arrangements.

The review process therefore provides **reasonable assurance** regarding the effectiveness of the governance framework supporting risk management.

However, whilst assurance can be taken regarding the quality of oversight and scrutiny arrangements, only **moderate assurance** can currently be taken regarding the effectiveness of controls and mitigating actions in reducing overall risk exposure. This is reflected by the fact that nine Corporate Risks remain above appetite and there has been limited movement in residual risk scores across much of the Corporate Risk Register.

4 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO** **KEY RISKS / MATTERS FOR ESCALATION**

- Nine of the eleven Corporate Risks remain above the Health Board's agreed risk appetite, indicating continued exposure to significant strategic risks
- Whilst governance, scrutiny and oversight arrangements continue to strengthen, there is limited evidence of measurable reduction in overall risk exposure across the Corporate Risk Register
- Workforce-related risks (CRR25-02 and CRR25-07) remain above appetite and continue to require focused Executive oversight and review
- Future reports should place greater emphasis on risk trajectories, control effectiveness and outcome measures to enable stronger assurance regarding progress towards risk appetite
- Audit Committee can take reasonable assurance regarding the effectiveness of governance arrangements; however, assurance regarding the effectiveness of mitigating actions in reducing risk exposure remains moderate.

5 **ARGYMHELLION** **RECOMMENDATIONS**

Audit Committee is asked to:

- **DERBYN SICRWYDD/TAKE ASSURANCE** that Corporate Risks are subject to appropriate oversight, scrutiny and challenge through Executive Committee, Board Committees and supporting governance structures.
- **DERBYN SICRWYDD/TAKE ASSURANCE** that improvements to the Corporate Risk Register framework have strengthened the quality, consistency and transparency of corporate risk reporting.
- **NODI/NOTE** that risks remaining above appetite continue to be escalated, monitored and reviewed through established governance arrangements.

- **NODI/NOTE** that whilst governance and assurance arrangements continue to strengthen, further work is required to demonstrate measurable reductions in risk exposure across the Corporate Risk Register.
- **CEFNOGI/SUPPORT** the continued development of outcome-focused reporting, including clearer reporting of control effectiveness, assurance gaps, risk trajectory and progress towards agreed risk appetite.

ASESIAD / ASSESSMENT		
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience	
	If more than one applies, please list below:	
Yr Egwyddorion Dylunio Design Principles	People First	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report

Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of the Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Have you completed an Integrated Equality Impact Assessment WP8a? WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ Administrative Report
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report

<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Administrative Report
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Resilient Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report

Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report. This report does not directly create additional resource requirements; however, it describes corporate risks which may have significant workforce, financial and estate implications if not effectively mitigated.

APPENDIX 1 – CORPORATE RISK REGISTER – AUGUST 2026



Corporate Risk Register



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CRR REF: 25-01 - Timely Patient Access to Safe and Effective Care				
Director Lead: Chief Operating Officer			Date Opened: 21/08/2025	
Assuring Committee: Quality, Safety and Experience Committee			Date Last Committee Review: 05/03/2026	
Date Last Reviewed: 30/04/2026	Link to BAF: BAF24-07		Target Risk Date: 30/06/2027	
Risk Detail: There is a risk that patients may not receive timely access to the care they need; for planned care this may lead to a delay in definite treatment, deterioration in health or harm occurring whilst waiting, poor patient experience, and poorer outcome. In the unscheduled care pathway, patients may experience harm whilst waiting for ambulances in the community, may have prolonged waits for specialist medical care, this could lead to patient harm and poor patient experience. This may be caused by capacity and demand mismatch, lack of oversight of waiting lists, lack of validation, the need to transform services and service models and delays due to waiting for diagnostic tests in the unscheduled arena it may be caused by poor flow through the health and social system, poor discharge practices, lack of appropriate residential and nursing placement. This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.				
Mitigations/Controls in place				
1. System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels 2. 6 week rapid improvement plan with clinical and operational executive oversight 3. Quality, professional and operational standards 4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned. 5. Winter Resilience Plan complete evaluation and lessons learnt. 6. Revised Access policy to ensure standardised practice across the Health Board 7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice 8. Same Day Emergency Care (SDEC) services established at all acute sites 9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance 10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 11. Diagnostic Quality Management System accreditation system embedded 12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts.	A UEC clinical lead has been appointed as part of the UEC programme team as well as other clinical leads specifically focusing on the priorities of the 6 goals plan within specific workstreams.	UEC Programme Director	Complete	Complete
	ED staffing business case for medical and nursing requirements including whole time equivalent and costings to be drafted for Executive Committee endorsement. Task & Finish group to be established to progress at pace with key leads including clinical, nursing, workforce and transformation and progress through HB governance. Outcome: A stable, sustainable UEC and frailty workforce with reduced reliance on locums, improved service continuity, and consistent delivery across all sites. Metric: Reduction in locum usage and vacancy rates in UEC and frailty posts, Impact on risk: Likelihood of risk will reduce as permanent posts are filled with further reduction expected as locum reliance decreases and workforce stability improves	Chief Operating Officer	Q1 2026/27 – 30/06/2026	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Fragility of social care provision causing delayed discharge and stranded patients	Implement reset 'sprint' fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance Second 'Sprint' undertaken 22 January – 4 February, supported by 3 diagnostics to target ongoing actions Action update: Further to completed actions, above, MADE events have been held on each site and further interventions have been identified including: >21-day length-of-stay reviews / 6As audits scheduled during March / April across all sites – findings will inform immediate and longer-term actions that strengthen discharge processes and system-wide UEC flow – supported by external improvement and intensive support team.	Chief Operating Officer	8/12/2025	Complete
	Deliver December "Discharge Fortnight" - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability. Action update: Fortnightly regional realignment meetings in place with BCU / LA to maintain focus on discharges to support flow and patient outcomes	Chief Operating Officer	31/01/2026	Complete
G3 Need for demand and capacity modelling and specialty-level trajectories	Complete demand and capacity analysis across Planned Care to inform forward activity planning Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a 'planned care sprint' to improve booking of long waiters into core capacity and transfers of care to appropriate services Outcome Clear understanding of specialty level- demand and capacity, enabling improved activity planning, reduced long waits, and more efficient use of core capacity Metric Reduction in number of long waiting patients (aligned to IMTP trajectory) Impact on Risk: Likelihood decreases as clearer planning reduces backlog risk and improves ability to meet demand.	Chief Operating Officer	30/06/2026	Progressing (revised date from 31/03/2026)

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G4 Inadequate Neurodevelopment (ND) capacity to manage waiting list	Eradicate all >3 year waits by end March 2026. Ministerial priority. At the end of March 2026 there were 646 over three year waits due to the private provider being unable to complete their contract assessment numbers. These referrals have now been allocated to another private provider for completion by the end of Quarter 1, families and schools have been updated. Additionally there will be 2,358 C&YP that will have waited over 3 years in 26/27, WG have allocated £2m to BCUHB to address the >3 year waiters, however this will be insufficient with a shortfall of approximately 490 assessment. WG are to be informed of this residual gap and options to manage reviewed Confirmation of funding allocation (£2m) from WG re 26-27 for ND funding for assessments, was received in April. Approval from Exec Committee & PFIG subsequently confirmed in April for the continued use and extension of the private provider contract for children's ND assessments to support delivery against WG expectations for 2026/27. Outcome The capacity gap has reduced significantly, supported by a 63% increase in assessment activity in 2025/26. This has been achieved through a prudent delivery approach alongside commissioning of independent providers. Allocated funding will support backlog reduction for waits exceeding 3 years in Q1 26/27, whilst also contributing to longer term service sustainability. Metric Ministerial milestone. Deliver and sustain no >3 year waits at the end of March. Impact on Risk Failure to maintain increased assessment capacity and targeted backlog reduction may result in continued waits exceeding three years into 2026/27. This would lead to non-delivery of the ministerial milestone, prolonged delays for neurodevelopmental (ND) assessments, increased demand pressures on services, and potential deterioration in patient outcomes and experience	Associate Directors Childrens	Qtr 1 2026/27 – 30/06/2026	Progressing
G5 Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics.	- Strengthen and enhance monitoring of reportable diagnostics through implementation of upgraded systems including: - RISP (radiology) – completed RISP radiology system September 2025 completed. - LIMs 2.0 (pathology) – ongoing roll out to be completed by end Q3 - Ensure existing services have mechanisms in place to report urgent and unsuspected findings, including Welsh Clinical Portal (WCP). Enhanced / divisional monitoring of reportable diagnostics as a byproduct of planned care backlog recovery programmes. This will develop further with diagnostics division throughout 2026-27 to include UEC and urgent suspected cancer diagnostics Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025 (NB: This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27) Outcome: improved oversight and strengthened reporting of findings / responsive actions Metric: reporting turnaround times maintained / improved, with outliers identified earlier for intervention Impact on Risk: overall reduction in likelihood of delayed diagnostic results to service users	Associate Director, North Wales Managed Clinical Services	30/06/2026 30/06/2026	Progressing

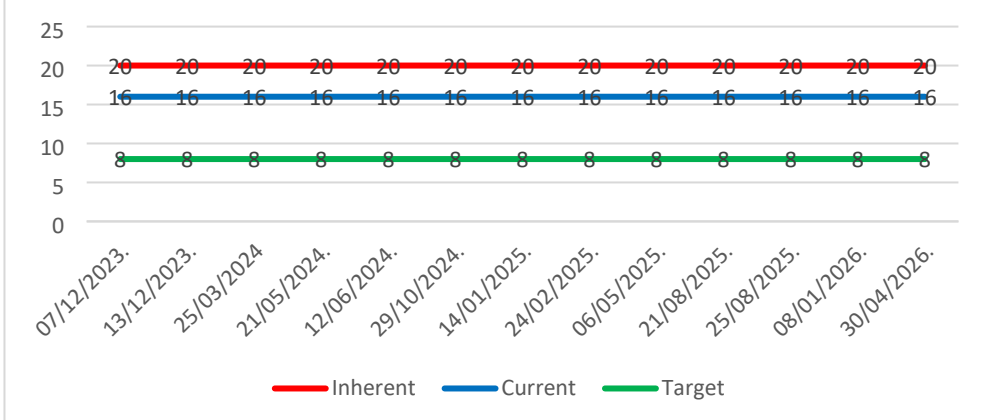
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G6 Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet Workforce recruitment impacted by non-recurrent (6 Goals) funding	- Complete pan BCUHB- baseline and gap analysis to inform a standardised frailty service model, develop unified Acute (front door) Frailty Services pathways aligned with SDEC and community services (Q2), Baseline and gap analysis completed - Finalise financial and workforce modelling required to deliver the national AFS model (Q1). Outcome A consistent, standardised frailty model across all acute sites, improving early assessment, flow, and access to same-day and community alternatives Metric Completion of baseline & gap analysis. Agreement of standardised AFS model for each site. Progress against recruitment to frailty workforce roles. Impact of Risk Risk reduces as variation decreases and standardised models strengthen service reliability and pathway consistency through pan BCU standardised approach.	UEC Programme Director	30/09/2026 30/06/2026	Progressing
G7 Consistent application of "Our Next Patient Please" flow model.	Patient flow improvements: Implement "Our Next Patient Please" Move patients to wards ahead of predicted discharges; reduce ED congestion. Completed – Our next patient (forward waiting) is now BAU	Chief Operating Officer	31/01/2026	Completed
	- Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways. Outcome Improved patient flow through earlier ward moves, reduced ED congestion, and strengthened use of alternative pathways and community services—leading to fewer unnecessary ED attendances and more efficient system-wide flow. Metric Reduction in ED congestion metrics (4 hour / 12 hour / time to triage / ambulance handover) - Reduction in LoS / POCD Impact on Risk Risk decreases as improved flow reduces system pressure, ED overcrowding, and delays in urgent and emergency care—lowering the likelihood and impact of service failure Action update: - Your Next Patient / Forward Waiting SOP developed - Accelerated Boarding in Extremis SOP developed	Chief Operating Officer	31/03/2027	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G8 Health Board improvement goal for Clostridium Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.	Implementation of Health Board improvement goal for CDI (Clostridium Difficile Infection) reductions in 2025/2026 <i>This action to reduce CDI is now based on the WHC Improvement Goals for 2025 – 2027. The Health Board has until March 2027 to reduce CDI by at least 25% against the 2024/2025 counts</i> Outcome Reduced incidence of Clostridioides difficile infection across the Health Board through strengthened infection prevention-, antimicrobial stewardship, and system-wide adherence to improvement measures. Metric CDI incidence rate per 100,000 population Impact on Risk Risk decreases as CDI rates fall, demonstrating improved infection control and reduced harm as performance moves towards the 2025/26 reduction target.	Deputy Director of Nursing Infection Prevention and Decontamination	31/03/2027	Progressing (revised date from 31/03/2026)

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk				
The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB were: 23 in 2023-24; 7 in 2024-25; 3 in 2025-26 to date. In 2023 the Health Board was an outlier and 9 cases directly related to the impact of delays in the health and social care system on the timeliness of responses by the HB and Welsh Ambulance Service and ongoing work is required to resolve the underlining delays to treatment. The goal being to be in line with WG targets. Intended Outcome: By 2027, patients consistently receive timely, effective, and safe care, evidenced by: - Reduction in long-wait patients (>104 weeks) and breaches of national access standards. - Fewer harm events linked to delayed care. - Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs). - Reduction in regulatory and legal cases associated with delayed access. - A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.				

CRR REF: 25-02 - Risk Title: Future Demand & Sustainable Workforce				
Director Lead: Executive Director of People and Organisational Development		Date Opened: 21/08/2025		
Assuring Committee: People & Culture Committee		Date Last Committee Review: 12/02/2026		
Date Last Reviewed: 30/04/2026	Link to BAF:	Target Risk Date: 31/03/2027		
Risk Detail: There is a risk that the Health Board does not have an effective, coherent workforce plan and workforce supply, that is based upon an incorrect funded establishment. This may be caused by the organisation not undertaking effective of demand and capacity planning, which may be compounded by high sickness rates and recruitment challenges. This may lead to staff burnout, reduced morale and retention and an inability to consistently deliver safe, high-quality care. This will likely place additional strain on services and impacting patient outcomes.				
Mitigations/Controls in place				
1. A new workforce planning framework has been agreed 2. A Healthy Workforce group is in place overseeing a comprehensive range of actions to improve sickness rates and employee wellbeing 3. The Foundations for the Future (FFTF) Board is in place to oversee the development of the future workforce model 4. The Board has approved the three-year culture change programme 5. A Value & Sustainability programme is in place, overseeing a range of initiatives to improve productivity and financial efficiencies 6. A recently introduce Medical & Dental policy advisory service is in place 7. Work around retention initiatives has seen a reduction in avoidable turnover				
Gaps in Controls/	Action	Action Owner	Due Date	Progression Analysis
G1 Implement a system-wide Workforce Planning service with reportable workforce plans across key services	Adoption of the workforce planning framework, based on the results of the demand and capacity review in conjunction with the clinical services plan	Chief Operating Officer, Executive Medical Director and Executive Director of Transformation and Improvement	31/03/2027	Will commence fully once D&C has been completed
G2 Demand and Capacity (D&C) forecasting	Full demand and capacity review that will identify true gaps in the workforce model	Finance and Performance	31/03/2027	Progressing
G3 An establishment review is required following D&C review	Undertake establishment reviews based on the outputs of the Demand & Capacity review	Finance and Performance	31/03/2027	Will commence fully once D&C has been completed
G4 An agreed operating model for the Health Board through the FFTF programme	Consultation and Implementation of the new operating model leadership structure. The first phase is Band 8c +	Senior Associate Director of People & Organisational Development(OD)	31/03/2027	Progressing
G5 Clinical Service plan that outlines workforce requirements	Engagement sessions are being held in May 26, a draft outline plan has been shared.	Executive Medical Director (Kamela Williams, support in Planning)	01/04/2027	Progressing
G6 M&D leadership and engagement is not fully effective	Strengthen the governance arrangements for the Medical Workforce Group, to report into the new Executive Delivery Group for People & OD	Senior Associate Director of People & OD	30/09/2026	Progressing
	To scope and put forward proposals for a wider Medical Staffing function in the People Service directorate	Senior Associate Director of People & OD	31/03/2027	Progressing
G7 M&D Job Planning policy	To approve and publish the new Job Planning procedure and meet the target of achieving 90% of M&D Job Plans being in place.	Executive Medical Director	31/03/2027	Progressing
G8 More effective workforce pipelines in fragile services	Within the overarching OD plan, Values Based Recruitment (VBR), values based induction and transition are being introduced as part of the new Health Board values implementation	Exec Director People & Organisational Development(POD)	31/03/2027	Progressing

G9 Absence and sickness management to deliver on ministerial targets and enabling actions	Targeted management of sickness absence. A Healthy Workforce group is in place and is overseeing the action plan to target reducing sickness absence rates, in line with the Welsh Government requirements by March 2026.	Deputy Director, People & Organisational Development	31/03/2027	Progressing		
	A range of actions are being worked on through this group, which are expected to be delivered by the end of 2026/27					
	A sickness deep dive paper was tabled at December 2025 People & Culture Committee which incorporates a series of initiatives that will help reduce sickness absence rates. The planned delivery for these is March 2027	Deputy Director, People & Organisational Development	31/03/2027	Progressing		
			Impact	Likelihood	Score	
		Inherent Risk Rating	4	5	20	
		Current Risk Rating	4	4	16	
		Target Risk Score	4	2	8	
		Risk Appetite	Quality <15	Not in Tolerance		
Position & Intended Outcome for Risk						
KPIs to that inform our risk in this area as at February 2026; Overall Vacancy rate of 8.1%; Target 8%. M&D, Add Clin Services, Healthcare Sciences, E&F and A&C above target Turnover stands at 7.1% and continues its downward trend from 7.9% this time last year. Sickness rates currently 6.08%; Target 4.2% Time to Hire currently 77 days; target 71 days						

CRR REF: 25-03 - Risk Title: Population Needs				
Director Lead: Executive Director of Public Health		Date Opened: 21/08/2025 (version 2 refined from 2023)		
Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 05/03/2026		
Date Last Reviewed: 29/06/2026	Link to BAF: BAF24-06/07		Target Risk Date: 31/03/2028	
Risk Detail: There is a risk that the organisation will fail to meet the health needs of the population and will not enable good health and wellbeing of the population. This may be caused by a failure to embed appropriate health prevention responses including areas such as immunisation, outbreak management and screening, failure to deliver interventions that improve people's health, increasing pressures in primary care, rising demand for chronic condition management, and insufficient capacity in children's, dental, and mental health services. This may lead to unmet health needs, preventable and communicable diseases, poorer health outcomes and widening inequalities for the North Wales population.				
Mitigations/Controls in place				
1. Recurrent funding secured for Healthy Weight / Healthy Wales programmes 2. Diabetes Programme established 3. Healthcare Public Health programmes support the integration of population health approaches within patient pathways 4. Approved Communicable Disease Plan in place with supporting procedures in place for some communicable diseases. 5. Primary Care Board and subgroups (dental, community pharmacy, optometry, GMS) provide cluster-level governance. 6. CHC (Community Health Council) teams and community escalation frameworks in place 7. Welsh Government Neurodevelopment transformation programme funding to support longest waiters 8. National referral pathways in orthodontics and Dentist with Enhanced Skills / Tier 2 provision. 9. Prevention, Population Health & Early Intervention Executive Delivery Group provides oversight of delivery. 10. The IMTP and National Planning Guidance 26/27 outline the requirement for health board focus on the development of population health intelligence and the submitted health board plan responds to this – Strategic Intent 1 11. Development of the Health Board Strategy, Clinical Services Plan and major programmes such as Community by Design and Foundations for the Future provide opportunity to integrate Prevention and Population Health into plans and are informed by identified population health priorities. 12. Regional Wellbeing, Prevention and Anchor Framework agreed by Health Board and Partners 13. Improvement on uptake against National Immunisation Framework achieved 25/26. 14. Health Needs Assessment and a scoping/insight review completed to understand the health needs and experiences of inclusion health groups (including Homelessness, Sex Workers and Asylum Seekers and Refugees). 15. Homelessness Insights paper prepared with recommendations to the Health Board for the upcoming duty to Ask, Act, and Cooperate within the Homelessness and Social Housing Bill (Welsh Government, 2026) 16. A community outreach offer designed to improve access to prevention and early intervention services for inclusion health groups. 17. Evaluation framework designed to measure the impact of the primary care continuity of care pathway for prison leavers. 18. Identification of unauthorised Encampments across North Wales and their proximity to GP practices, to increase access to primary care provision for Gypsy, Roma and Traveller people. 19. Health Equity Checklist to support the Health Board's strategic planning by ensuring that services are designed and delivered in ways that address health inequalities. 20. Inclusion of Prevention and population health priorities are implicit in Strategic intent priorities 2,3 and 4 and the Corporate Risk has been updated to reflect gaps in controls which are addressed through integrated deliverables throughout the Health Board Annual Delivery Plan.				
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Limited system-wide prevention leadership and prevention not consistently prioritised	Weight Management Steering Group to develop a plan which addresses recommendations from the BCUHB Weight Management Service review Outcome: Improved organisational oversight of provision to support weight management and improvement of population healthy weight priorities Metric: Access to services and success rates Expected Impact on Risk Score Reduction: Services reflect the needs of the population with a prevention and health improvement focus. Action Update: 29/4/26 Report received outlining recommendations, which will inform 26/27-28/29 IMTP plans. next steps in terms of the plan have been incorporated into the Draft delivery plan which supports the IMTP 26.27. Identify variation across North Wales in service delivery.	IHC Director – Weight Management Services	31/03/2026	Progressing

	26/6/26 – (links to Annual Delivery Plan 1A.2) Programme Group established, reporting progress against Annual Delivery Plan. Awaiting outcomes of national work in relation to digital weight management offer which will support progress, however we continue to move forward with level 2 and level 3 digital offers locally.			
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
The plan in place for the management of communicable disease outbreaks (in and out-of-hours) within BCUHB requires testing / simulation and socialising to ensure effectiveness	Health Board can demonstrate robust plans are in place and tested for Communicable disease outbreak management across its services and functions. Outcome: Improved preparedness for the identification and management of communicable disease threats. Metric: The Health Board response to communicable disease threats, the existence of plans and pathways for the management of communicable disease threats, the numbers of staff trained in preparedness measures (including HCID PPE training, and FFP3 face fit testing), the existence and delivery of health board simulation exercises. The evaluation of data on disease incidence and infection rates within BCUHB settings. Expected Impact on Risk Score Reduction: Strengthened preparedness within the Health Board for the identification and management of communicable disease threats. Action Update: 29/04/2026 (links to Annual Delivery Plan 1D) - The Strategic Communicable Disease Preparedness Group continues to meet with an agreed ToR however attendance is poor and the group remains un-quorate despite being in existence for 12 months. No response following submission of a paper to QSE in March 2026. HCID PPE trolleys are available in each of the 3 IHC hospitals but training in the use of the HCID PPE ensemble remains low with 22 staff trained across the Health Board (including 2 trainers). There is only 1 staff member trained in the West IHC where engagement appears particularly poor. Independent GP practices continue to lack fit testing for FFP3 masks, continuing the additional risk that GP practices will refer patients with suspected communicable diseases to secondary care. The revised pathway for Rabies Post-Exposure Prophylaxis remains un-approved despite being submitted for approval in Dec/Jan. There has been no progress on a national level to review GP contracts to include health protection medicines. BCUHB areas of weakness identified by recent cases and incidents include the ability (or lack of) to provide post-exposure vaccination to the contacts of Hepatitis A cases, or Invasive Meningococcal Disease cases. These were brought to the attention of the Chief Executive during a corporate directorate review on the 24th April 2026 where it was agreed that further executive level discussion was required. A successful HCID/pandemic preparedness exercise took place on the 15th April and was represented by a number of services from across the Health Board and Welsh Government and Public Health Wales. The findings from the event will help develop the Health Boards pandemic plan and encourage IHCs to re-instate their HCID	Assistant Director Of Health Protection, Public Health	30/09/2026	Progressing

	preparedness meetings (IHC East met on 28th April 2026). 29/6/26 – As a result of two high profile health protection incidents (Andes Hantavirus outbreak on board the MV Hondius, and an outbreak of Ebola in the Democratic Republic of Congo and Uganda), a number of activities have taken place since early May to improve preparedness measures for communicable diseases (with a focus on High Consequence Infectious Diseases in particular). Activities included the convening of a BCUHB IMT (Initially for Andes Hantavirus, and subsequently HCIDs), the development of plans and pathways within YGC for managing symptomatic contacts of Andes Hantavirus, improving the numbers of staff trained in the HCID PPE ensemble. The consideration of paediatrics, maternity and MHL D into HCID planning and preparedness. Whilst each of the 3 IHCs are at different stages in their preparedness, the international focus on HCID has resulted in improved focus on this particular issue. However, despite the increased interest and attention, attendance at the Strategic Communicable Disease Preparedness group remains poor, and the group is likely to be disbanded and incorporated into the Strategic Infection Prevention Group (this is yet to be approved). The plans and pathways for HCID will be tested with a 'mystery shopper' exercise in July. An education session on HCID was provided to medical staff in YGC with teams links to East and West. The Rabies Post Exposure Prophylaxis pathway has been approved and has been used successfully. A response to a case of Hepatitis A in a primary school class room assistant resulted in approximately 90 contacts within the setting (children and teachers) requiring Hep A vaccine. The response was successful and will be used to develop a vaccination outbreak response pathway for BCUHB. Welsh Government have made contact with BCUHB following the simulation exercise that took place on the 15th April. Welsh Gov want to incorporate a short overview of this exercise in a national evaluation of Exercise Pegasus in Wales			
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Inconsistent commissioning approach across community and primary care services.	Develop a Community and CHC Strategic Plan with Local Authorities. <i>*Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk*</i>	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing
	Implement surge and escalation plans with Local Authority partners for community flow <i>*Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk*</i>	Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2026	Progressing

Fragility of Neurodevelopment workforce and reliance on temporary funding	Management of CYP (Children and Young People) needs, ND workforce business case submitted to the Executive Team, decision on the case deferred pending a broader review of funding priorities No approval received in relation to business case submitted, focus for this financial year is on utilising additional non-recurrent funding received from WG to reduce longest waiters Two private providers commissioned for ND assessments over 3 years, one provider delivering as per contract, the other provider is in breach of contract in relation to the assessments completed, as such there will be approximately 700 over 3-year waiters at the end of March. Awaiting communication from WG re 26-27 ND funding for assessments, plan is to continue use of one provider, all procurement and contract arrangements are in place. A briefing update has been shared with WG colleagues. <i>*Legacy item 24/25 CRR Framework - This does not form control for this Corporate Risk - this is a service level issue</i>	CAMHS Programme Management Business Lead, Child & Adolescent Health	31/03/2026	Progressing (revised date from 31/12/2025)
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Lack of restorative dentistry service and workforce pipeline	Undertake a dental diagnostic deep dive to inform strategy In 2025 a review of the primary care dental service was undertaken to look at the current challenges in both General Dental Services (GDS) and the Community Dental Service (CDS). Key issues were identified in areas including leadership, performance, process, finance and people management. Progress within the service is now being monitored at a senior level via the IPEDG group, and a senior clinical review of the service is being planned for earlier 2026. <i>*Legacy item 24/25, 25/26 CRR Framework - This does not form control for this Corporate Risk - this is a service level issue - Restorative Dentistry service is not part of this risk.*</i>	Assistant Director Of Primary Care (Dental)	31/03/2026	Progressing
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on health improvement	1) Progress Strategic Intent Priority 1 deliverables 'Focus on Health and Wellbeing' Workstream 1A – Preventative Approaches to health & wellbeing Outcome: Healthier communities with fewer people smoking, more people with healthy weight and in better physical and mental health. Greater preventative focus across the life course. Metric: - Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks. % Improvement in Breastfeeding rates at birth and at 10 days - Increase the proportion of children in Wales who are a healthy weight by halting the rise, and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged. - Level 2 Adult weight service – increase activity rates - Tiny Tums – increase number of settings who achieve Tiny Tums award	Consultant in Public Health (Health Improvement Programme)	31/03/2027	Progressing

	• Increase family programmes via schools – Come and Cook Expected Impact on Risk Score: Most care delivery in the NHS now relates to long-term conditions the majority of which have significant preventable factors. Preventable health measures should consider all stages across the life course – from pre-conception and into older age. This can reduce the likelihood and severity of chronic illness, reducing flow towards acute settings 25/6/26 – 1A.3 - Grant funding confirmation for Prevention and Early years, Whole Schools Approach and Healthy Weight Healthy Wales received into the health board. Agreements and plans in place – focus on weight, smoking, breastfeeding and early years. 1A.6 – Health Improvement offer is under development which considers where opportunities lie to implement changes and improvements to delivery and health outcomes within the health board. 1A.9 – 15 organisations across North Wales are now engaged with the Healthy Travel Charter 1A.10 – Organisational campaign planned to improve uptake of ‘Make Every Conversation Count’ training			

Gaps in Controls	2) Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on Healthcare Public Health including disease prevention and managing health outcomes	2) Progress Strategic Intent Priority 1 ‘Focus on Health and Wellbeing’ Workstream 1B – Proactive strategies for disease prevention, frailty & falls Outcome: More proactive care of frail people, reducing falls and the need for healthcare services. Increased screening services for cancer improving early identification and management. Fewer complications linked to diabetes due to improved monitoring and management. Health Board can demonstrate a clear prevention and health inequalities focus in its major strategic plans and services. Metric: - Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. - Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months. - Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months. - National screening targets. Expected Impact on Risk Score: Falls and frailty are a significant driver of demand across primary and acute NHS Services and is expected to increase. Applying data and evidence through population health management will allow the organisation to target action within identified population groups towards where there is a strong likelihood of a health risk occurring, develop tailored interventions to prevent or reduce the impact of health risks which would contribute to preventing further deterioration, and optimise how the early stages of disease is detected. Intervening in the early stages of disease can prevent the disease from progressing, allows people to self-manage their health, improves health outcomes, prevents the individual developing other health conditions and ensures that people can continue to live their lives fully within their families and communities. 26/06/26 – 1B.1 – Population Management post advertised – this is a senior post with focus on development population health intelligence which will inform service and organisational planning. 1B.5 – Diabetes programme structure to support place based approaches for Diabetes are being established with initial practice level work being initiated. Initial work underway to understand challenges and opportunities at a cluster and GP level 1B.6 – Diabetes 8 Care processes - Work underway to establish access to GP level data and to establish offer to practices that have the lowest levels of uptake.	Consutant in Public Health (Health Care Public Health & Population Health Management Programmes)	31/03/2027	Progressing

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on reducing health inequalities	3) Progress the Strategic Intent Priority 1 ‘Focus on Health and Wellbeing’ Workstream 1C – Health Inequalities Outcome: Reduced risk factors linked to the wider determinants of health such as environmental, social and economic factors. Improved equity of access between most and least deprived areas in relation to vaccinations, screening and diabetes care. All services and strategic plans should have metrics that enable them to assess the potential health inequalities in delivery. Metric: • Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and Diabetes prevention and care. • National screening uptake targets - reduction in variation, increase in uptake from inclusion groups • Vaccination targets - reduction in variation, increase in uptake from inclusion groups • Diabetes 8 Care Processes – reduction in variation, increase in uptake from inclusion groups Expected Impact on Risk Score: Inequalities will continue to widen if we do not embed population health approaches in pathways and service plans that can enable the organisation to target resources proportionate to need. Through understanding the needs of communities, the Health Board can better enable provision of care in the right way, in the right place, and at the right time. The Health Board cannot reduce health inequalities alone. Many factors which impact on health and wellbeing require commitment and coordinated action across public sector organisations, enabled through the organisation’s role and opportunity as an Anchor institute. Together, the right social, economic and environmental conditions can be created that allow health and wellbeing to flourish. 26/6/26 - 1C.2 – Vaccine Equity Plan in draft and 1C.4 engagement plan for primary care partners drafted 1C.3 – Screening inequalities data sourced and reviewed to inform Screening Equity Plan 1C.6 – Anchor Charter – systems engagement events have taken place and findings alongside ‘Missions’ for focus presented to Regional Partnership Board 1C.7 - Homelessness insights implementation plan developed. Community prevention outreach offer developed for the Traveller community.	Consultant in Public Health (Health Inequalities Programme)	31/03/2027	Progressing

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on health protection	4) Progress the Strategic Intent Priority 1 ‘Focus on Health and Wellbeing’ Workstream 1D – Health Protection Outcome: More people in the population are protected from increased uptake of vaccinations with a particular focus on vulnerable groups. People are protected against existing, new and emerging health hazards. Communicable outbreak plan developed and tested, providing assurance to the Health Board and partners. Metric: • <i>Percentage uptake of the following targeted measures:</i> • Children who are up to date with all routine scheduled vaccinations by age 5. • Children receiving the Human Papillomavirus (HPV) vaccination by the age of 15. • Influenza vaccination amongst adults aged 65 years and over Applicable during: 01.09.2026 - 31.03.2027. • Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old. • Influenza <65 at risk • Influenza - Staff • MenACWY Cml (Y10) Expected Impact on Risk Score: Health Protection focuses on preventing harm before it happens and keeps communities safe from communicable and other notifiable illness that could affect large numbers of the population at scale. Risk of infectious diseases include Flu, Measles, and M-Pox, with disease outbreaks having a significant impact on closed settings such as care homes and schools. Health Protection includes the management of vaccine preventable disease risks such as measles, outbreak control planning, and training and education in settings to support Infection Prevention Control (IPC). 26/06/26 – 1D.1 School Immunisation Programme : The e-consent app is on track to be introduced for the School based Flu immunisation programme for winter 2026-2027. RSV older adult programme : Reflecting on lower uptake within this cohort and an expansion to the eligibility , the integrated vaccination service and primary care partners have adopted a cohort specific co-administrated focus for the Covid-19 Spring programme to optimise delivery alongside improving RSV uptake rates 1D.5 – increased sampling and new vaccination pathways established 1D.6 - Annual residential Care Homes IP&C reviews have commenced.	Assistant Director Health Protection / Deputy Director Vaccs & Imms	31/03/2027	Progressing

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on Primary and Community Care	5) Progress against the Strategic Intent Priority 2 - Enhanced Co-ordination of Care deliverables which will directly contribute to improving population health and keeping people well for longer. This includes focused deliverables: - <i>Development of Health and Wellbeing Hubs</i> - <i>Primary Care contracting inc Dental</i> - <i>Progression of Community by Design</i> - <i>Delivery of Frailty and falls prevention models</i> - <i>Delivery of Weight Management and smoking cessation services</i> - <i>Diabetes management</i> - <i>Health and wellbeing of Children & Young People</i> Outcome: More co-ordinated care in the community for people with long term conditions. Better access to community based preventative care. Metrics: • Percentage of population (adult) receiving NHS dental care over a 24-month period - General Dental Services (GDS) • Percentage of population (child) receiving NHS dental care over a 12-month period - General Dental Services (GDS) • Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes. • Percentage of patients (aged 12 years and over) with diabetes who have had foot surveillance recorded within last 15 months. • Percentage of patients (aged 12 years and over) with diabetes who have had their urine albumin recorded within last 15 months. • Percentage of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans. • Number of staff undertaking MECC Expected impact on Risk Score: A well-functioning Primary Care system is essential to improving population health outcomes, supporting the shift towards prevention and early intervention, and delivering a more sustainable, prudent healthcare model for the future. Community-based services are essential to improving outcomes through prevention, early intervention, and supported self-management. Providing care within local communities makes services more accessible, improves user experience, and helps reduce inequity by removing practical, geographical, and socioeconomic barriers to care-based services which is essential to improving outcomes through prevention, early intervention, and supported self-management. Health and Wellbeing Hubs bring together physical health, mental health, social care and community wellbeing services in one accessible location, creating a “no wrong door” approach that enables earlier intervention, smoother referrals and more holistic care. By embedding prevention and public health activity within local communities, they help address the wider determinants of health, promote	AD Primary & Community Care	31/03/2027	Progressing

	independence and reduce avoidable demand on acute services. 26/6/26 - 2A.7 – development of plans in relation to use of the Adult Plus Frailty tool 2B – Community by Design is progressing as expected through the ‘Discovery’ phase 2C – Health & Wellbeing hubs programme continues to make progress against plans for implementation – different stages for different hubs			

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on secondary care, clinical pathways and specialist services	6) Progress against the Strategic Intent Priority 3 - Improve Access, outcomes and experience for all deliverables which will directly contribute to improving population health and keeping people well for longer. This includes deliverables which focus on: – <i>BCU community falls response resource</i> – <i>Providing falls prevention training across Care Homes</i> – <i>BCU MHL D physical health policy in line with national developments.</i> – <i>Reducing inequality and variation in access to services and pathways</i> – <i>Digitally delivered specialist All-Wales gambling harm and treatment service</i> – <i>CAMHS Early Help systems and processes</i> – <i>Healthy Child Wales 2 Programme</i> – <i>Childhood diabetes – prevention and management</i> – <i>Women's Health - prevention and early intervention, including preconception health and earlier identification of women's health conditions</i> – <i>Support the National Lung Screening Programme and other National screening programmes including reducing of variation</i> – <i>Support staff to complete MECC training</i> Outcomes: People who fall in the community are treated outside of acute hospitals where they are more likely to de-condition. Patients are directed to the most appropriate service, freeing up resources such as ambulances and emergency departments. . A modern, people-centred healthcare system A clear long-term vision and strategy for our clinical services across North Wales, and an organisational structure that enables its delivery. Improved quality of maternity services including reduced perinatal mortality rates. Improved waiting times for people of all ages with Mental Health, Learning Disabilities and Neurodevelopment. More people supported with substance misuse. Metrics: • Reduce avoidable ambulance conveyances and ED admissions from Care Homes through providing falls lifting equipment and level one falls prevention training to be delivered to 30 Care Homes across North Wales. • Reduce avoidable ambulance conveyances and ED admissions from the community by developing a proposal to use Six Goals Programme funding to increase Community Resource Teams (CRT) capacity, focused on mobilising Band 3 therapy support staff as a dedicated pan BCU community falls response resource. • Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services. • Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	ADs / Programme Leads – UEC, Planned Care, C&YP CAMHS, MH & LD, Womens	31/03/2027	Progressing

	• Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment • National screening targets • Childhood Measurement Programme participants • Percentage of C&YP waiting less than 26 weeks to start neurodevelopment assessment • Number of staff undertaking MECC Expected impact on risk score: Earlier diagnosis leading to better health outcomes. Prevention of deterioration and ill health or worsening conditions which impact on health and wellbeing. Reducing the gap in health outcomes for people with mental health and learning disabilities, supported by a focus on prevention, early intervention and reducing health inequalities. An integrated, responsive system where people receive the right care, in the right place, at the right time. Reduction in health inequalities and variation within clinical pathways of care. 26/06/26 – 3A – Falls prevention training and Falls lifting equipment delivery plan finalised for Care homes 3D.6 reduce inequalities for LD patients - Patient-facing support focusing on facilitating the uptake and delivery of health checks for patients, particularly those in hard-to-reach locations, through our Health Liaison Team and 'Lab in a Bag' initiatives. 3F.8 - Development of a strategic plan for children with a learning disability, and reduce inequalities for consultation - on track following meeting with Childrens CCAG 3F.2 - gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme 3G.6 local delivery of the NHS Wales Women's Health Plan across North Wales - Confirmed funding allocation both locally and nationally to expand on the Women's Health Hub as detailed within the National Women's Health plan 2025-2035			

Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
Develop and improve system-wide prevention through consistent prioritisation and integration with a focus on system-wide approaches, Enabling services, strategy and pan BCU delivery	10)Progress against the Strategic Intent Priority 4 - Create a modern people centred healthcare system deliverables which will directly contribute to improving population health and keeping people well for longer. This includes deliverables which focus on: - <i>Population health management</i> - <i>Development of key plans and strategies</i> - <i>Embedding prevention as a core component and enabler of major programmes</i> - <i>Develop organisational understanding of population health needs and priorities</i> - <i>Develop collaborative partnership working which tackles wider factors which impact on population health and wellbeing such as employment and environment.</i> - <i>Funding models which support movement of services towards primary and community settings</i> Outcomes: Improved and more resilient systems, data and insights to support better day to day delivery of safe services and their improvement. More research and innovation projects and collaboration with education partners to provide improved health care for the future. Improved value for money services ensuring that precious resources are spent to deliver maximum benefit to the population. Better experience and outcomes for the population. Metrics: • Develop the measures of success in relation to both population and patient outcomes as well as the strategy development process. • Planning maturity matrix self-assessment scores (Population Needs Assessment is part of this) • Develop the measures of success in relation to both population and patient outcomes as well as the CSP process for those areas selected in the first tranche of the CSP. • High Value High Impact pathway analysis • Increase proportionate spend on Primary and Community Services Expected Impact on risk score: The Health Board can evidence informed decision making based on population health management data and intelligence. The Health Board can demonstrate response to population need and the impact on service delivery and resourcing. 26/6/26 – 4B – Development of Strategy continues through Discovery phase, considers prevention and population health. 4D.12 – Facilitate transformation through targeted activity - Early milestones relates use of data to inform a regional Warm Homes initiative in collaboration with local government and progressing recruitment to newly developed Population Health Management Team roles 4K – quantify current spend on primary and community services re strategic move to proportionately increasing investment into primary and community care - database is being developed to enable clear identification of Primary and Community cost centres and spend	AD Planning / DDAT, Transformation, Estates, Finance, VBH	31/03/2027	Progressing



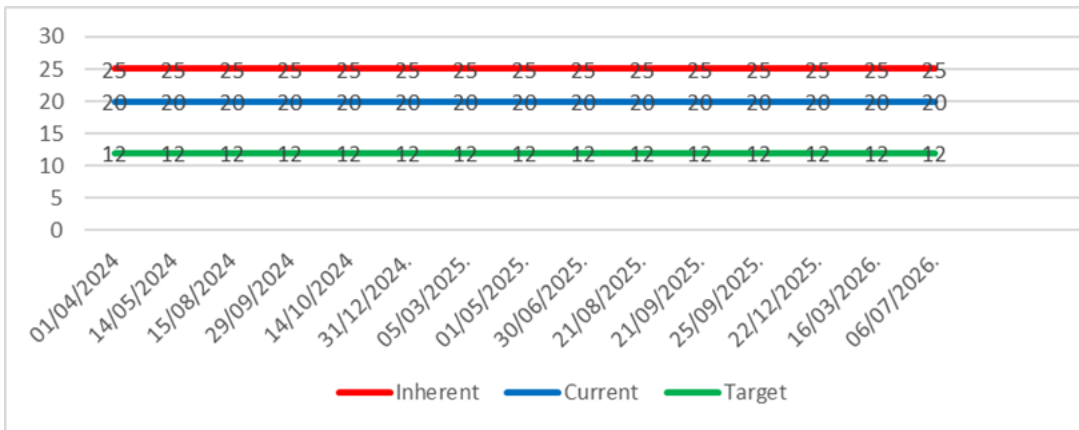
CRR REF: 25-05 - Risk Title: Strategic Change – Impacting Care and Staff Delivery				
Director Lead: Executive Director of Transformation and Strategic Planning		Date Opened: 21/08/2025 (version 2 refined from 2023)		
Assuring Committee: Planning, Population Health & Partnership Committee		Date Last Committee Review: 05/03/2026		
Date Last Reviewed: 05/05/2026	Link to BAF: BAF24-02	Target Risk Date: 26/11/2026		
Risk Detail: There is a risk that patients may not benefit from planned improvements in care, access, and outcomes if the HB does not effectively implement or develop its strategic change programmes. This may be caused by a lack of momentum in delivering change, unclear or underdeveloped clinical strategy, competing ministerial priorities, and inconsistent transformation efforts across clinical services. This may lead to inefficiencies, missed opportunities to modernise care, continued misalignment between service delivery and patient needs, patient harm from long waiting times, delays, and backlog reviews, and increased frustration or disengagement among staff tasked with delivering change.				
Mitigations/Controls in place				
1. Scrutiny and oversight of strategy development work by the Strategic Planning and Service Change Group (SP&SC Group a sub-group of the Executive Committee), Planning Population Health and Partnerships (PPHP) Board Committee and the Health Board to ensure robust governance arrangements and timely escalation; which are important for enabling foundations for successful delivery of strategic change and co-production of the 1) Strategic Intent for North Wales with partners, 2) 10 Year Strategy for the Health Board, 3) Clinical Services Plan 2. Priority change programmes in place for the organisation 1) Major Change Programmes (Planned Care; Urgent and Emergency Care; Value and Sustainability; and Foundations For The Future), 2) Key Programmes (grouped into: Mental Health; Llandudno Planned Care hub; Improving safety, efficiency and effectiveness through digitisation; Diagnostics improvement; and Health and Well-being Hubs), 3) Challenged Services (Dermatology, Ophthalmology, Vascular, Urology, Oncology, Plastics, Orthopaedics, Orthodontics). 3. Change programmes controls in place and monitored by the Transformation and Improvement team to ensure they are run consistently and best practice project, programme and portfolio management is applied. As well as providing an objective and independent assessment of progress and areas of risk. 4. Oversight and scrutiny of the Major Change Programmes tracking progress, risks, and dependencies by the Executive Committee, relevant Board Committee and Health Board. The Key Programmes reports into SP&SC Group, PPHP and Health Board. 5. The Challenged Services report into SP&SC Group for review and oversight, Quality, Safety and Experience Committee (QSE) and Health Board. 6. External oversight and scrutiny is provided by Welsh Government via IQPD and JET as well as quarterly Challenged Services review meetings. 7. Terms of References for all groups with clear routes to escalation. 8. Legal and policy compliance including adherence to Welsh Government (WG) service change guidance. 9. Continued development of the portfolio management and reporting approach for all priority change programmes, including monthly monitoring of high risks across all priority programmes. 10. Mobilisation of the Challenged Services oversight group that will report into the SP&SC Group.				
Gaps in Controls	Actions	Action Owner	Due Date	Progression Analysis
G1 Completion of the strategy development work, moving into the execution phase.	Complete Strategic Intent for North Wales with partners, presenting to Health Board for approval Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: COMPLETED. Four Strategic Intent Statements were co-created, tested and refined with key partners. They were reviewed by PPHP on the 14th of January and subsequently approved by the Board on the 29th of January. Following Board approval, the Statements were used to provide the strategic planning framework for the 2026/29 three-year plan replacing the previous five Strategic Priorities.	Head of Health Strategy and Planning, Transformation & Strategic Planning	31/01/2026	Completed
G2 Organisational approach to change management to be developed and implemented.	Organisational approach to change developed as one of the enabling products within Foundations for The Future programme Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: Further work has been scheduled into 26/27 as part of the service level plan, to ensure full engagement in this work. Successful sessions have been held with the Executive team and the Stakeholder Reference Group. A discovery phase report is being finalised for presentation to the Strategic Planning and Service Change group on the 4 th June, and a time-limited group of key stakeholders is forming around the design elements. This will lead to an organisational change framework which is scheduled for completion in Q3.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	26/11/2026	Progressing (revised date from 31/03/2026)

Gaps in Controls/	Action	Action Owner	Due Date	Progression Analysis																																												
G3	Complete the diagnosis phased of the Health Board’s 10 Year Strategy, including an implementation plan for the remaining programme of work Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: Due to competing pressures with the strategic intent and capacity constraints this work has rolled into 26/27 and will complete before the end of Q1. This will include endorsement through governance and be supplemented by a detailed and time-bound implementation plan for the delivery phase of the 10yr Strategy.	Head of Health Strategy and Planning, Transformation & Strategic Planning	30/06/2026	Progressing (revised date from 31/03/2026)																																												
G4	Complete preparations for phase 2 of the Clinical Services Planning (CSP) work, including an implementation plan Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: A CSP engagement event with senior clinical leaders is taking place on the 5th May. Preparatory work underway, with initial CSP engagement event scheduled for 5th May. This event is one of the final steps in the preparation phase which is now expected to complete by the end of Q1. The day is designed to build a shared purpose and initiate the development of a new CSP for BCUHB. The CSP has now been adopted as a major change programme during 26/27 and a fully programme plan will be put in place.	Head of Health Strategy and Planning, Transformation & Strategic Planning	30/06/2026	Progressing (revised date from 31/03/2026)																																												
G5	Implement changes to portfolio management and reporting based on feedback on early iterations of reporting across all the priority programme areas, including monthly monitoring of high risks across all priority programmes.<i>Work is now complete and will continue to evolve as part of business as usual. Iterative changes have been made and the reporting has been very well received by Board Members for both Key Programmes and Challenged Services, with Board members stating that they feel more assured. Highlight reports in place for each programme/service in scope with summarised reporting through the Strategic Planning and Service Change Group and onwards to PPHP and Board.</i> Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: No further update in this period as now complete.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete																																												
G6	Mobilise the Challenged Services oversight group that will report into the SP&SC Group<i>This is complete. The first meeting was held on the 28th November with the next meeting scheduled for the 26th January, with the group developing plans for the regionalisation of services and transitioning into broader Clinical Services Plan work.</i> Expected Impact on Risk Score Reduction: Impact rating not expected to change. Overall likelihood is expected to reduce from 3 to 2 when all 6 actions are complete but individual actions alone will not affect the score. Action Update: No further update in this period as now complete.	Assistant Director of Transformation and Improvement (Interim), Transformation & Strategic Planning	31/12/2025	Complete																																												
<table><caption>Risk Score Data</caption><thead><tr><th>Category</th><th>21/08/2025</th><th>01/10/2025</th><th>31/12/2025</th><th>05/05/2026</th></tr></thead><tbody><tr><td>Inherent</td><td>16</td><td>16</td><td>16</td><td>16</td></tr><tr><td>Current</td><td>12</td><td>12</td><td>12</td><td>12</td></tr><tr><td>Target</td><td>8</td><td>8</td><td>8</td><td>8</td></tr></tbody></table>		Category	21/08/2025	01/10/2025	31/12/2025	05/05/2026	Inherent	16	16	16	16	Current	12	12	12	12	Target	8	8	8	8	<table><thead><tr><th></th><th>Impact</th><th>Likelihood</th><th>Score</th></tr></thead><tbody><tr><td>Inherent Risk Rating</td><td>4</td><td>4</td><td>16</td></tr><tr><td>Current Risk Rating</td><td>4</td><td>3</td><td>12</td></tr><tr><td>Target Risk Score</td><td>4</td><td>2</td><td>8</td></tr><tr><td>Risk Appetite</td><td colspan="2">Quality <15</td><td>In Tolerance</td></tr><tr><td colspan="4">Position & Intended Outcome for Risk</td></tr></tbody></table>				Impact	Likelihood	Score	Inherent Risk Rating	4	4	16	Current Risk Rating	4	3	12	Target Risk Score	4	2	8	Risk Appetite	Quality <15		In Tolerance	Position & Intended Outcome for Risk			
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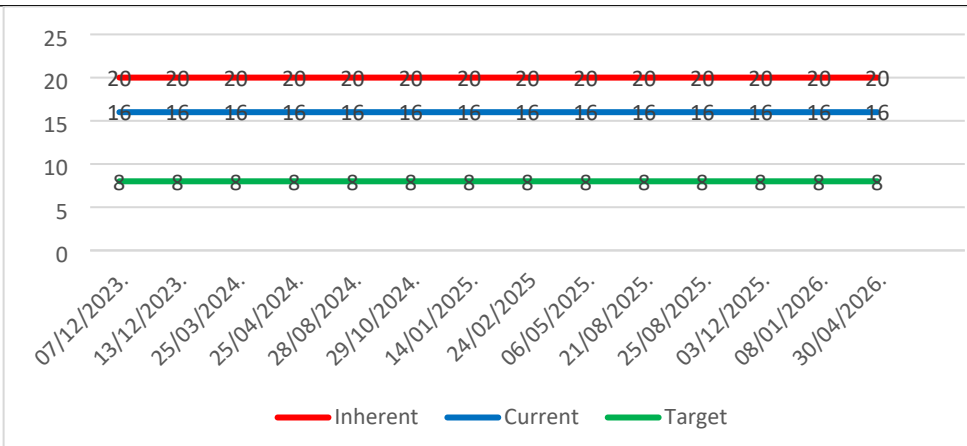
CRR REF: 25-06 Risk Title: Delivery of the 2026/27 Financial Plan and Financial Sustainability				
Director Lead: Executive Director of Finance			Date Opened: 01/04/2026	
Assuring Committee: Performance, Finance and Information Governance Committee			Date Last Committee Review:	
Date Last Reviewed: 06/07/2026	Link to BAF: BAF24-03 / financial sustainability		Target Risk Date: 31/03/2027	
There is a risk that the Health Board will be unable to deliver the 2026/27 financial plan and to demonstrate a credible route to longer-term financial sustainability. The plan is set within a zero-investment framework and includes a planned deficit of £43.0m, a recurrent savings requirement of £46.0m and significant reliance on delivery of savings, grip and control, and receipt/retention of anticipated Welsh Government allocations. This may be caused by inflation and unavoidable cost pressures exceeding the 1.11% allocation uplift; recurrent impacts from 2025/26 cost pressures; growth and price pressures in commissioned services, prescribing, secondary care drugs and CHC; unfunded national pressures including Welsh Risk Pool, digital/Microsoft licensing and additional NWJCC contributions; pressures in Out of Area Mental Health placements and escalated capacity; and insufficiently mature savings and disinvestment plans. This may lead to failure to achieve the planned deficit trajectory and key financial duty, loss or non-retention of conditionally recurrent strategic funding, reduced ability to fund essential services and transformation priorities, further escalation and scrutiny, and increased risk to safe, timely and high-quality care.				
Mitigations/Controls in place				
- Monthly financial reporting to Welsh Government through the Monthly Monitoring Return and internal Health Board reporting, including forecast outturn, risks and opportunities. - Performance, Finance and Information Governance Committee oversight, with financial and performance information shared routinely. - Executive and divisional governance over targeted investment allocations, including Performance and Transformation, Planned Care, Value-Based Healthcare, Further Faster and other specific Welsh Government allocations. - Continuation of 2025/26 Grip and Control measures into 2026/27, including additional non-pay expenditure controls for non-clinical categories, scrutiny of Travel Bureau requests and Stores orders, procurement review of pending Oracle requisitions and cancellation where not critically urgent. - Pay controls and added oversight over non-clinical external recruitment and clinical posts prior to recruitment, with scrutiny of temporary workforce use through Clinical Executive leadership. - Value and Sustainability thematic savings model across Clinical Value, Workforce, Continuing Healthcare, Medicines Management and Non-Pay & Procurement. - Savings identification and monitoring through the Green/Amber/Red pipeline, with Welsh Government action point deadlines for schemes to meet required classification by 30 June 2026 and conversion requirements by 30 September 2026. - Continued scrutiny of agency, locum and variable pay, including delivery against the Cabinet Secretary enabler target of a 30% agency cost reduction. - Ongoing review of reserves, central budgets, virements and forecast categorisation to improve transparency of cost pressures, mitigations and underlying deficit. - Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. - Accountability Agreements to be issued to the budget managers for sign off in support of funding and deliverables required for each financial year. The signing off for these agreements monitored for review by Internal Audit and performance reported through Committees of the Health Board - Integrated Performance and Accountability Framework 2026-29 adopted by Board on 28 May 2026 - Escalation meetings in place with key budgets holders and Chief Executive for July 2026 for those services / divisions that have not underwritten their savings targets at the end of June 2026.				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Month 2 position is adverse to plan, with an in-month deficit of £5.6m, £2.0m adverse to profile, a year-to-date deficit of £10.9m and cumulative savings shortfall of £5.0m.	Maintain enhanced monthly financial recovery and run-rate review through Executive, IP-EDG and PFIG Committee oversight. Outcome In-month deficit and year-to-date adverse variance are contained and brought back towards the profiled planned deficit trajectory. Metric In-month variance to plan; cumulative deficit to plan; run-rate movement by division. Impact on Risk Reduces likelihood of further deterioration and supports delivery of the £43.0m planned deficit.	Executive Director of Finance / Chief Executive Officer	Monthly to 31/03/2027	Progressing

G2 The plan relies on retention of conditionally recurrent strategic Welsh Government funding; loss of this funding is identified as an £82.0m risk and would materially worsen the underlying position.	Maintain evidence against conditions attached to strategic funding and ensure clear escalation where delivery or de-escalation requirements are at risk. Outcome Conditions for retention are explicitly tracked and risks escalated early. Metric Condition tracker RAG; evidence of delivery; value of funding at risk. Impact on Risk Protects critical income and reduces exposure to a significantly larger underlying deficit.	Executive Director of Finance / Executive Team	Monthly to 31/03/2027	Progressing
G3 Savings plans are not yet sufficiently mature to bridge the full requirement: £13.3m Green schemes were identified at Month 2 against a £46.0m target, with £31.9m Red schemes and pipeline opportunities still to be converted.	Accelerate conversion of pipeline and Red/Amber schemes to Green, with recurring/non-recurring split and delivery confidence reviewed monthly. Outcome A greater proportion of the £46.0m savings requirement becomes assured and deliverable. Metric Green schemes £m and % of target; recurring savings £m; YTD delivery against profile; pipeline conversion rate. Impact on Risk Reduces risk of unachieved savings and reliance on non-recurrent mitigations.	Executive Director of Finance / Value & Sustainability Leads / Divisional CFOs	30/09/2026 and monthly thereafter	Progressing
G4 Unplanned cost pressures are being reported and offset by unplanned spend reductions after virements, indicating volatility and complexity in interpreting run-rate, recurrent impact and genuine mitigations.	Strengthen monitoring return reconciliation and recurrent/non-recurrent classification, with monthly CFO check-and-challenge on cost pressures, spend reductions and virements. Outcome Improved clarity of the underlying position and fewer late adjustments. Metric Reconciliation issues resolved; value of items moved to correct category; forecast accuracy. Impact on Risk Improves financial grip and enables earlier corrective action.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing
G5 Inflationary and cost pressures exceed available allocation uplift, particularly CHC, Prescribing, Secondary Care Drugs, commissioned services, NWJCC/cross-border contracts, Welsh Risk Pool and digital pressures.	Maintain targeted pressure reviews and confirm mitigations/disinvestment proposals for high-risk categories, supported by benchmarking and contract scrutiny. Outcome Material pressures are quantified, mitigated and escalated through the financial governance route. Metric Pressure value by category; mitigation value identified; residual forecast variance. Impact on Risk Reduces likelihood that unavoidable pressures destabilise the plan.	Executive Director of Finance / Central Finance / Divisional CFOs	Monthly to 31/03/2027	Progressing
G6 Grip and Control measures may not deliver sufficient recurrent impact or may not be fully captured in the financial plan.	Quantify the impact of continued Grip and Control measures across non-pay, procurement, pay and temporary workforce, and report delivery through monthly returns. Outcome Savings and run-rate reductions attributable to Grip and Control are evidenced and sustained. Metric Value of requisitions cancelled/approved; non-pay reduction; recruitment controls impact; temporary workforce spend trend. Impact on Risk	Executive Director of Finance / Executive Directors / Procurement and Workforce Leads	Monthly to 31/03/2027	Progressing

	Supports run-rate containment and reduces reliance on unidentified mitigations.			
G7 Agency and variable pay remain material risks, with Month 2 agency spend of £2.6m and variable pay of £8.5m, and 2026/27 variable pay forecast increasing from Month 1.	Maintain executive scrutiny of agency, locum, bank and overtime, including action plans against the 30% agency reduction enabler and temporary workforce controls. Outcome Agency and variable pay are reduced where clinically safe and affordable. Metric Agency spend £m/% of pay; variable pay forecast; delivery against 30% reduction target. Impact on Risk Reduces pay overspend and supports workforce affordability.	Executive Director of Finance / Executive Director of Workforce / Clinical Executive Leads	Monthly to 31/03/2027	Progressing
G8 Conditionally funded performance and transformation schemes are forecast to spend £42.0m in full, creating a need for strong benefits tracking and clear disinvestment/alternative funding where relevant.	Track programme spend, benefits and recurrent consequences for Performance and Transformation, Planned Care, Value-Based Healthcare and Further Faster allocations. Outcome Strategic funding supports agreed priorities without creating unfunded recurrent commitments. Metric Spend vs forecast; benefits delivery; recurrent consequence assessment completed. Impact on Risk Protects affordability and value for money while supporting transformation.	Director of Transformation / Executive Director of Finance / Programme SROs	Quarterly to 31/03/2027	Progressing
G9 Forecast assumptions depend on full receipt of anticipated income, including pay award funding and other RRL assumptions; misalignment with Welsh Government allocations would increase forecast risk.	Continue monthly confirmation of RRL assumptions and anticipated allocations with Welsh Government, including pay award estimates and working balances support. Outcome Income assumptions are validated, and any funding gaps are escalated early. Metric Confirmed vs anticipated RRL; value of unconfirmed allocations; pay award estimate variance. Impact on Risk Reduces risk of unidentified income shortfalls affecting forecast outturn.	Executive Director of Finance / Deputy Director of Finance	Monthly to 31/03/2027	Progressing
G11 Risks and opportunities identifies total quantified risks and no / low quantified opportunities	Maintain monthly risk and opportunity review to ensure risks are reflected in forecast where clear and evidenced. Outcome The forecast position remains aligned to the risk register and MMR Table A2. Metric Quantified risks/opportunities £m; movements since prior month; forecast inclusion status. Impact on Risk Improves transparency and supports early mitigation or escalation.	Executive Director of Finance / Central Finance	Monthly to 31/03/2027	Progressing

		Impact	Likelihood	Progressing
	Inherent Risk Rating	5	5	25
	Current Risk Rating	5	4	20
	Target Risk Score	4	3	12
	Risk Appetite	Financial/VfM <15		Not in Tolerance
Position & Intended Outcome for Risk				
At Month 2, the Health Board is reporting material financial sustainability risk for 2026/27. The plan is not balanced and is forecasting delivery of the planned £43.0m deficit, supported by receipt of anticipated income, retention of conditionally recurrent strategic funding and delivery of a £46.0m savings requirement. The year-to-date position is already adverse to plan, with savings delivery below profile. The intended outcome is to contain the run-rate, strengthen the recurrent savings pipeline, improve confidence in forecast assumptions and demonstrate clear evidence that savings, grip and control, disinvestment and value-based opportunities can reduce the forecast risk over the year. The target risk score remains outside the Financial/VfM appetite until there is sufficient assurance that recurrent savings are deliverable, conditional funding is secure and the forecast deficit is aligned with a credible route to financial balance.				

CRR REF: 25-07 Risk Title: Leadership and Operating Model				
Director Lead: Executive Director of People and Organisational Development			Date Opened: 21/08/2025	
Assuring Committee: People & Culture Committee			Date Last Committee Review: 12/02/2026	
Date Last Reviewed: 30/04/2026		Link to BAF: 25-04	Target Risk Date: 31/03/2027	
Risk Detail: There is a risk that the Health Board does not deliver high quality patient care aligned to operational plans, or not meeting HB targets or adhering to legislative requirements. This may be caused by not building and maintaining an effective culture and leadership environment, or developing the necessary skills and knowledge of our leaders. This may lead to poor organisational culture and behaviours which in turn will lead to low staff morale, poor patient care and inefficient services for the population of North Wales.				
Mitigations/Controls in place				
1. Speak Out Safely Multi Disciplinary Team (MDT) and Work in Confidence platform for staff to raise concerns 2. Organisational Culture Change Plan and Behaviours Framework approved by Board and is being deployed 3. Integrated Leadership Development Framework (ILDF) in place 4. Improved nurse retention results over the last 2 years 5. Clear top-down commitment to reinforce leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed) 6. Increased uptake on the 2025/26 staff survey 7. 60% of senior staff trained in leadership through conferences and masterclasses 8. New all Wales Flexible Working policy in place – monitored at the People and Culture Committee 9. Organisational Development (OD) plans are in place in 2026/27 to support recruiting well and joining well, for example Values Based Recruitment and Corporate induction				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 - Leadership development pathways not fully integrated	Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched April 2026. This will be used to inform the mid-level management ILDF leadership courses / resources design. There has been a delay in HEIW launch of Management Competency Framework Mid level pilot to commence in May 26 this has been delayed due to financial restrictions on training. Evaluation of programmes completed for Q1 & Q2 with Q3 & Q4 due May 26. People Managers forum evaluation underway for first 12 month roll out	Head of Organisational Development Workforce & Organisational Development	30/09/2026	Progressing
G2 Outdated PADR process and system in place	A new values and behaviours based PADR system will be deployed in 2026. It is expected this programme will show results within the first year following the launch	Head of Organisational Development, People & OD	30/09/2027	Progressing
G3 Leadership taking on board and acting on staff survey results	Assess and agree the actions based on the 2025 staff survey results. The preliminary results are in. The next phase is for each service to confirm the localised actions in place to address the necessary actions in their areas	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing
	A paper detailing the key findings from the NHS Wales Staff Survey 2025 and suggested next steps in response to feedback (including areas of focussed action) will go to the Board in May 2026. Directors received the results for their areas of responsibility in early March to inform discussions and action and teams across the organisation have access to HEIW'S survey dashboard to review performance and identify improvement opportunities. Briefings have also been held through established forums including local People and Culture Committees.	Head of Employee Engagement and Experience – Corporate Office	30/06/2026	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis		
G4 Capacity in delivering planned programmes of work alongside FFtF without any additional resource in OD, this may impact on the timelines for delivery	Review and prioritise workload in the OD function in 2026/27 to accommodate FFtF	Deputy Director, People & OD	30/09/2026	Progressing		
G5 Fully implemented culture change programme that will demonstrate improved KPIs	Implement Employee Engagement Plan with suite of indicators The actions underway listed below are part of the 2025-26 plan for culture and engagement. The 2025 staff survey result will be used to assess the impact these actions have had. It is expected the result will be available in early 2026. - Embedded new engagement listening approach including staff stories being shared at People and Culture Committee, Local Partnership Forum and more widely to support organisational understanding and learning. - Refreshed reward and recognition activity to introduce monthly recognition awards ‘Seren Betsi’ with Executive involvement, improved annual staff achievement awards event. A new approach to recognise 25 & 40 years service will be ratified in the April 2026 P&CC - Staff survey champions will be trained to support local monitoring and reporting	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing		
	Deliver Culture Change Plan with Comms and Engagement rollout. P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development,	30/06/2026	Progressing		
	Quarterly Culture, Leadership & Engagement Plans finalised and monitored P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development, Workforce & Organisational Development	30/06/2026	Progressing		
G6 Regular culture performance reporting at IHC/Directorate level	Introduce culture reporting at IHC level. A new dashboard to be deployed in Q1 26/27 to track Y1 performance against corporate and divisional target	Deputy Director, People & OD	30/09/26	Progressing		
			Impact	Likelihood	Score	
		Inherent Risk Rating	4	5	20	
		Current Risk Rating	4	4	16	
		Target Risk Score	4	2	8	
		Risk Appetite	Quality <15		Not in Tolerance	
Position & Intended Outcome for Risk						
The general feeling is culture and engagement had improved with the recent workstreams, however, the FFtF change programme is expected to impact this and will test organisational resilience KPIs to that inform our risk in this area as at February 2026; Staff retention 91.4% compared to 90.7% last year. PADR compliance 80%, compared to 78.95% last year The number of Grievance cases is 5 compared to 13 this time last year The percentage of stress & anxiety absences remains high at 1.8% which is over 1.2% this time last year The trend of speak out safely cases have remains static, but shows a 40% decrease from this time last year						

CRR REF: 25-08 Risk Title: Non-Compliance with Regulatory and Legislative Requirements				
Director Lead: Director of Corporate Governance		Date Opened: 21/08/2025		
Assuring Committee: Audit Committee		Date Last Committee Review: 06/11/2025		
Date Last Reviewed: 16/07/2026	Link to BAF: BAF24-01	Target Risk Date: 31/03/2027		
Risk Detail: There is a risk that the Health Board may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care. This may be caused by inefficiencies in managing regulatory complexities and changes at pace, ineffective relationship management with regulators and statutory bodies, inadequate monitoring and reporting of actions and progress, including escalation, and insufficient operational assurance. This may lead to enforcement action, impact patient safety, financial penalties, impact on workforce, and loss of public and stakeholder confidence.				
Mitigations/Controls in place				
1. Internal and external audit reviews identifying and reporting areas of non-compliance with legislation and regulation. 2. Report on progress on some regulatory compliance submitted to the Regulatory Assurance Group, Executive Quality and Delivery Group, and Quality, Safety and Experience Committee via the Integrated Quality Report. 3. An update on progress on some regulatory compliance from the Integrated Quality Report also included in the Statutory Compliance Report to Executive Committee and Audit Committee. 4. Monitoring of regulations and legislation by various groups, such as: – Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication – Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans. – Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls)				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 The Health Board currently lacks a complete and consolidated picture of its regulatory and statutory relationships, leading to limited visibility over roles, responsibilities, and engagement practices.	Capture current relationship management practices and arrangements around Health Board regulators and statutory bodies Complete a structured mapping exercise of all regulators and statutory bodies across the Health Board to identify lead Executive Team member, operational lead, and current relationship with these bodies 16/07/2027 – The latest version of the Regulatory Relationship Management Matrix was presented to the inaugural meeting of the Governance and Regulatory Executive Delivery Group on 7 July 2026. Executive Team members have been asked to review the information contained within the Matrix and provide any comments, amendments or additional information as required. Initial discussions indicated that the Matrix is largely comprehensive and captures the majority of known regulatory, statutory, professional and oversight body relationships. The Group agreed to use the Matrix as the primary mechanism for oversight of external regulatory and professional body relationships. A programme of rolling review will be established, with the Group identifying priority regulators and bodies for detailed discussion at future meetings to ensure appropriate governance, assurance and relationship management arrangements are in place. As the Matrix has been developed, presented to the Group and adopted as a tool to support ongoing oversight and monitoring, it is recommended that this action be closed, with future review and maintenance of the Matrix being undertaken through the Governance and Regulatory Executive Delivery Group.	Head of Statutory Compliance and Inquiries	31/07/2026	Completed
	Outcome			

	• A clear, consolidated view of how the Health Board currently manages relationships with regulators and statutory bodies • A baseline understanding that supports improved coordination, compliance, and strategic engagement • Clarity, visibility, and baseline understanding. Metric • Confirmation from each Executive Team member that details of all regulators and statutory bodies under their portfolio have been captured Impact on Risk • Increased visibility of current relationship management practices with its regulators and statutory bodies across the Health Board • Increased visibility of the current reporting and monitoring practices relating to regulator and statutory body information across the Health Board • Increased visibility of roles and responsibilities relating to regulators and statutory bodies.			

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 There is no fully reliable or validated register of regulatory relationships and statutory obligations, creating uncertainty around ownership, assurance, and compliance oversight	Review of regulatory and statutory body relationship management, reporting and monitoring arrangements 16/07/2027 – The Regulatory Relationship Management Matrix was presented to the inaugural meeting of the Governance and Regulatory Executive Delivery Group on 7 July 2026. The Group noted that, whilst the Matrix contains a significant amount of information relating to regulatory, statutory, professional and oversight bodies, some sections remain incomplete. In many cases, this reflects the absence of formal processes or arrangements rather than missing information. As such, the Matrix will remain a live document and will continue to be reviewed and updated as governance arrangements mature and additional information becomes available. The Group agreed that the Matrix will be used to inform its programme of work, with regulators and other external bodies being identified for focused review and discussion at future meetings. This will form part of the Group's routine cycle of business and will support ongoing oversight, assurance and the continual development of relationship management arrangements across the Health Board. Review the Relationship Management Matrix. Outcome • A strengthened, authoritative information set that can be used confidently by the Board, Executive Team Members, and operational teams • Identification of strengths, gaps, inconsistencies, and duplication in governance practices • An assessment of whether the existing information is sufficient to support assurance, compliance oversight, and regulatory engagement • A foundation for designing a more consistent, risk-aligned regulatory engagement framework Metric • Completeness — proportion of regulators/statutory bodies for which full information exists • Clarity of ownership — proportion of entries with clearly assigned responsible officers or teams. Impact on Risk When the information is complete and reliable: • Regulatory risk decreases because the Health Board has a clear, accurate understanding of all obligations and expectations • Ability to identify gaps in the improvements required to strengthen our processes • A verified, up-to-date record of all regulatory relationships and obligations, with inaccuracies corrected and gaps identified.	Head of Statutory Compliance and Inquiries	28/08/2026	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3 There is no formalised executive-led forum providing consistent oversight, coordination, and escalation of governance, statutory compliance, and regulatory issue	Executive Governance and Regulatory Group Formalise a multi-disciplinary Governance and Regulatory Group to provide routine scrutiny, coordination, and escalation. 16/07/2027 – The first meeting of the Governance and Regulatory Executive Delivery Group was held on 7 July 2026 and was well attended by Executive and senior colleagues. Constructive discussions took place regarding the future direction, priorities and governance arrangements for the Group. In response to feedback received, the duration of future meetings has been increased to allow sufficient time for discussion and oversight. Meetings have also been scheduled for the remainder of 2026/27. The Group's Terms of Reference were reviewed and discussed at the inaugural meeting, with feedback incorporated into a revised draft. The updated Terms of Reference will be presented for further consideration at the next meeting. At the next meeting on 15 September 2026, the Chair will present a forward workplan and standing agenda items for future meetings. Due to this, the due date for this action has been extended. Outcome A formalised, multi-disciplinary Executive Led Group to ensure consistent oversight, aligned decision-making, and timely escalation across governance, statutory compliance, and organisational assurance domains Metric • Group established with agreed terms of reference • Clear, defined and documented reporting and escalation processes • Attendance and representation across disciplines. Impact on Risk Formalising this Group will have a material positive impact on organisational risk exposure, the key improvements include: • Clearer escalation routes ensure strategic risks receive timely executive attention • More coordinated oversight supports consistent compliance across operational divisions • Improved accountability reduces drift, variability, and unmanaged exposures • Systematic monitoring ensuring the Health Board maintains compliance with statutory duties and regulatory frameworks • Provides clearer lines of sight for Board Committees	Head of Statutory Compliance and Inquiries	15/09/2026	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis																																									
G4 The Health Board lacks a centralised system to record, monitor, and assure compliance with legislative and regulatory requirements, resulting in fragmented and inconsistent oversight.	Compliance Management System Implement a centralised compliance management system to capture and enable the monitoring of Health Board-wide legislative and regulatory requirements <i>16/07/2026 - Work continues on the scope within DDaT to include the IT security, infrastructure and integration requirements. Once this has been finalised, the procurement process can commence.</i> Outcome Implementation of a centralised electronic system provides a single source of information for all legislative, statutory, and regulatory requirements, linked directly to named accountabilities and real-time assurance. Metric - System procured - System live by agreed date Impact on Risk Implementation of the system will have a significant positive effect on reducing organisational risk in multiple categories. - Ensures the organisation maintains a live, accurate register of all legislative and regulatory duties - Strengthens evidence trails for external inspections (for example Health Inspectorate Wales, Audit Wales, Health and Safety Executive) - Clear ownership of responsibilities reduces operational ambiguity and the risk of requirements being missed - Real-time visibility enables early escalation of compliance risks before becoming significant failures - Moves the Health Board from reactive to proactive compliance management - Reduces inconsistencies across directorates, improving confidence in assurance processes - Supports Board Committees by providing reliable, validated, accessible assurance information - Demonstrates to regulators and external stakeholders a systematic, robust approach to compliance - Automated reporting reduces human error, version-control issues, and information gaps - Ensures a clear audit trail for decisions, updates, accountability, and evidence.	Head of Statutory Compliance and Inquiries	31/03/2027	Progressing																																									
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<table><caption>Risk Rating Data</caption><thead><tr><th>Date</th><th>Inherent</th><th>Current</th><th>Target</th></tr></thead><tbody><tr><td>21/08/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>25/08/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>01/10/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>01/12/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>18/12/2025</td><td>20</td><td>16</td><td>8</td></tr><tr><td>26/02/2026</td><td>20</td><td>16</td><td>8</td></tr><tr><td>03/03/2026</td><td>20</td><td>16</td><td>8</td></tr><tr><td>27/04/2026</td><td>20</td><td>16</td><td>8</td></tr><tr><td>16/07/2026</td><td>20</td><td>12</td><td>8</td></tr></tbody></table>		Date	Inherent	Current	Target	21/08/2025	20	16	8	25/08/2025	20	16	8	01/10/2025	20	16	8	01/12/2025	20	16	8	18/12/2025	20	16	8	26/02/2026	20	16	8	03/03/2026	20	16	8	27/04/2026	20	16	8	16/07/2026	20	12	8	Inherent Risk Rating	4	5	20
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Governance and regulatory EDG to be set up to oversee compliance, and to track non-compliance to ensure risks are mitigated, reporting areas of non-compliance to the Executive Committee. This risk has been developed into a more strategic risk, which will encompass overarching compliance to statutory requirements across the Health Board.																																													

CRR REF: 25-09: Risk Title: Safe Environment				
Director Lead: Director of Environment and Estates		Date Opened: 04/01/2024		
Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 24/02/2026		
Date Last Reviewed: 22/06/2026	Link to BAF: BAF24-03	Target Risk Date: 31/03/2030		
Risk Detail: There is a risk that patients may be exposed to unsafe, uncomfortable, or unsuitable care environments if the organisation’s estates and infrastructure are not maintained to appropriate standards. This may be caused by ageing estate, backlog maintenance, and gaps in fire safety, health and safety compliance, and alignment with the estate’s strategy. This may lead to safety incidents, non-compliance with statutory duties, and barriers to service modernisation.				
Mitigations/Controls in place				
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £17m for 25/26 approved by Welsh Government with an allocation of approximately £3.45m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff. 7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below and oversee risks relevant to the groups: a. Fire Management b. Asbestos Management c. Water Safety, d. Ventilation Safety e. Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance 10. Capital Allocation from Welsh Government – additional capital funding of allocated to the Health Board to focus on Backlog Maintenance 11. The Health Board submitted the Major Capital prioritisation plan to Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to the Health Board from WG. The 10 year capital investment requests align with the capital prioritisation form that we will submit to Welsh Government. 12. Updated agreed protocol for use of Annual Discretionary Slippage in place for developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG. 13. Review of Reinforced Autoclaved Aerated Concrete (RAAC) completed by the Health Board’s approved structural engineers – Curtins and a report will be presented at the Strategic Occupational Health and Safety Group 14. Targeted Estates Funding (TEF) approved by Welsh Government and allocation of £15.390m awarded over a 2-year period (2025-2026 / 2026/2027) to progress the national programme of capital schemes for Fire, Infrastructure, Decarbonisation, Mental Health, Infection Prevention Control and Decontamination				
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 6-facet surveys to be undertaken to obtain an updated report of the condition of the Estate’ this will inform the risk status by site, which will be assessed against the controls currently in place. Additional mitigation or strengthening of controls will also be considered.	Facet Survey Undertake actions to deliver a facet survey across the Health Board over the next 2 years. Due to financial constraints within the Health Board a review of the facet survey programme is being undertaken to confirm which facets are a priority for the Health Board. Facet 1 - Physical Condition Survey (Fabric and M&E) Facet 2 - Statutory Requirements (Risk Based Methodology for Establishing and Managing Backlog) Facet 3 – Space Utilisation (Scope to be finalised) Outcome Deliver a phased, prioritised partial Facet Survey Programme across the Health Board over the next 2 years, ensuring a comprehensive understanding of estate condition, statutory compliance, space utilisation and backlog risk. Due to financial constraints, conduct a review to determine which facets are critical to informing investment decisions, focusing initially on Facet 1 (Physical Condition: Fabric & M&E) and Facet 2 (Statutory Requirements / Risk-Based Backlog). The outcome is to produce accurate, site-wide data that underpins capital planning, operational risk management, and strategic estate development.	Head Of Operational Estates	31/03/2028 (Subject to funding)	Progressing Due date extended from 31/03/2027 to 31/03/2028

	Metric Programme Scope & Completion - Completion of Facet 1 and Facet 2 surveys for all major acute, community, and mental health sites within 3 years. Data Quality & Integration - Survey data validated and uploaded into estates asset management systems (e.g., MICAD and future CAFM plans). Buildings or zones with complete, up-to-date backlog and condition profiles Backlog & Statutory Risk Assessment - Reduction in “unknown” condition/risk items within asset registers (target: elimination). Development of a risk-based statutory compliance backlog for Facet 2. Alignment With Capital Plans - Capital bids or business cases supported by validated facet data. Use of Facet 1 and 2 outputs to prioritise high-risk backlog items in annual capital allocation. Alignment with developing clinical service plans – to ensure optimum utilisation of the retained Estate and disposal opportunities for lease hold properties and redundant or obsolete Estate Impact on Risk Delivering this programme will: Reduce strategic and financial risk by ensuring investment decisions are based on validated, prioritised, and risk-driven estate data rather than assumptions or incomplete surveys. Mitigate statutory non-compliance through a clear understanding of high-risk areas within Facet 2, enabling timely intervention and reducing exposure to regulatory enforcement. Lower operational risk by identifying critical M&E, structural, and fabric issues early, preventing service disruption, safety incidents, or unplanned ward/department closures. Improve organisational assurance, giving the Board confidence that estate condition, backlog maintenance, and statutory risks are transparently understood and being managed in a structured, evidence-based manner. Strengthen long-term planning, ensuring the estate strategy, clinical strategies, and capital programme are all informed by a consistent, Health Board-wide dataset. Reduce reputational risk, demonstrating responsible stewardship of the estate and a proactive approach to addressing backlog and compliance issues before they compromise patient care.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC’s) and other services and the Estates/Capital teams – linked to the changes to the Operating Model.	Develop ToR Develop a standardised Terms of Reference to be considered and endorsed by Capital Investment Group Outcome A standardised, comprehensive, and governance-compliant Terms of Reference (ToR) is developed and endorsed by the Capital Investment Group. This ensures consistent governance, clarity of responsibilities, improved decision-making, and strengthened assurance for capital planning, prioritisation, and delivery across the Health Board. Metric Development & Approval - Revised ToR to be drafted and aligned with SFI and SoRD - ToR reviewed by required stakeholders (Capital Planning, Finance, Clinical, Estates). - ToR formally endorsed by the Capital Investment Group. Quality & Governance Compliance - Alignment with HB governance framework and Welsh Government capital governance. - Evidence of clear roles, responsibilities, delegated authority, and reporting lines within the ToR. Implementation - ToR published and communicated to all relevant stakeholders within agreed timescale.	Director of Environment and Estates	31/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure, and review of capital processes.

	Impact on Risk Governance Risk Reduction • Reduces ambiguity around decision-making, leading to robust capital approval process • Ensures consistent application of governance standards across capital schemes. • Strengthens audit trail and assurance for internal/external scrutiny (WG, Audit Wales). Strategic & Operational Risk Reduction • Ensures that roles, responsibilities, and authority for capital decisions are clearly defined, minimising project delays or misaligned decisions. • Enhances reliability of capital programme delivery through improved oversight. Compliance & Regulatory Risk Reduction • Reduces likelihood of non-compliance with Welsh Government capital governance requirements. • Supports consistent, well-governed business case progression.			

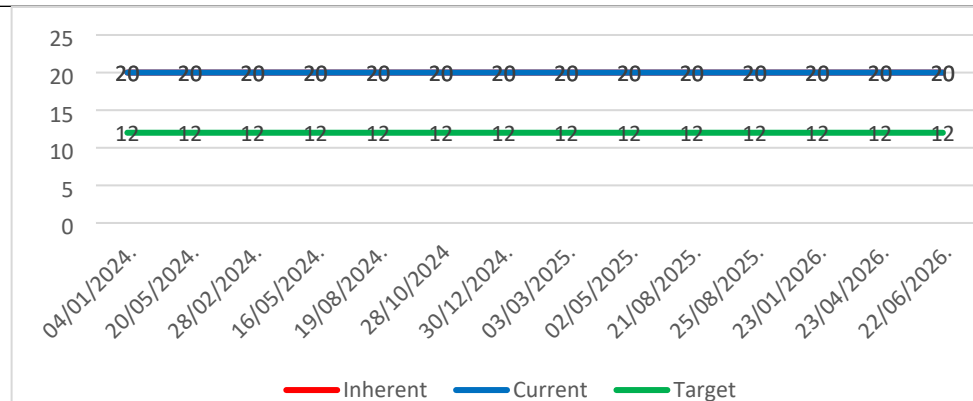
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3 Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance.	Estates Rationalisation Programme Undertake action to deliver a Health Board Estates Rationalisation Programme. Estates Rationalisation Programme being developed and in draft format. The Draft will be submitted to a multi-disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group. Health Board Rationalisation Programme to be presented to CIG on 12th September 2024. Estate's rationalisation plan is being reviewed and updated taking into account disposal that have been approved in 2024-2025 and opportunity for disposals in 2025-2026 as part of rationalisation of our estates that supports the Caledfryn Project. Outcome Deliver a comprehensive Health Board-wide Estates Rationalisation Programme that identifies, prioritises, and progresses opportunities for estate disposal, consolidation, and optimisation, utilising information received from the HB Clinical Plans and Estates Condition Survey. This includes producing a fully developed Estates Rationalisation Plan—currently in draft—to be reviewed by a multidisciplinary group and ratified by the Capital Investment Group (CIG), with formal presentation scheduled for September 2026. The programme will be updated to incorporate approved disposals within financial year. Metric: Programme Development & Governance - Draft Rationalisation Programme completed and submitted to the multidisciplinary review group. Final Estates Rationalisation Plan to be approved by the Board. Delivery of Approved Disposals - Number and value (£) of estate disposals completed. Progress planned disposal opportunities for 2026–2030. Estate Consolidation & Space Efficiency - Total reduction in estate footprint through rationalisation. Under-utilised space to be identified and addressed through disposal, consolidation, or repurposing. Financial Impact - Revenue savings delivered through reduction of lease, utility, security, and maintenance costs (year-on-year increase). Capital receipts generated from disposal of surplus estate (reported annually). Impact on Risk Delivering the Estates Rationalisation Programme will: Reduce financial risk - Lowering the cost of maintaining under-utilised, poor-condition, or non-compliant estate assets, and by generating capital receipts that can be reinvested in priority clinical infrastructure. Mitigate operational risk, ensuring that estate resources are focused on the most functional, safe, and strategically aligned sites, reducing exposure to failures in aged or inefficient buildings. Lower compliance and statutory risk by enabling the Health Board to phase out high-risk assets where the investment required to achieve compliance is disproportionate to clinical benefit. Improve organisational assurance, Demonstrating to CIG, the Board, and regulators that the estate is being actively and responsibly managed through structured, risk-based rationalisation. Reduce reputational risk, as proactive rationalisation demonstrates efficiency, and commitment to improving the quality and sustainability of the estate.	Head Of Operational Estates	30/03/2028	Progressing Due date extended from 31/03/2026 to 30/03/2028. Aligned with Facet Survey Programme

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G4 Internal Audit review of Fire Safety – Agreed Management Action Plan being implemented and being managed through the Fire Safety Management Group	Non-Compliance with Fire Safety Ensure the HB is fully compliant with Fire Safety Infrastructure on all sites (acute and Community) YG - Health Board submitted a PBC to address the Fire Safety and Infrastructure compliance issues on the Ysbyty Gwynedd site through the Welsh Government Infrastructure Board. In response to Programme Business Case Welsh Government have asked the Health Board to identify within the Programme Business Case those elements that relate to Fire safety only. Wrexham Maelor - Health Board submitted a PBC to address the infrastructure compliance issues on the Ysbyty Maelor site (Wrexham Resilience Programme) through the Welsh Government Infrastructure Board. In response to Programme Business Case, Welsh Government have asked the Health Board to identify high risk priority improvement projects Outcome Achieve full statutory compliance with fire safety legislation across the Health Board estate by implementing all required actions identified in the Fire Safety Audit/Firecode compliance assessment. This includes ensuring fire precautions, compartmentation, detection and alarm systems, evacuation procedures, maintenance regimes, training, and governance arrangements fully meet regulatory and NHS Firecode standards to protect life, property, and continuity of clinical services. Metric Fire Audit Action Completion Rate - Fire safety audit actions completed within agreed timescales WHTM 05 Compliance Level - Measured compliance against HTM 05-01/02/03 requirements, including structural fire precautions, fire alarm and suppression systems, and management arrangements (target: full compliance or approved derogations). Fire Safety Training Compliance - staff completing mandatory fire safety training and evacuation drills. Number of Fire Incidents & Unwanted Fire Signals (UWFS) - Reduction in fire incidents and UWFS across the estate (target: continual reduction and compliance with national UWFS targets). Impact on Risk Significantly reduce risk to life - by ensuring effective fire detection, containment, and evacuation arrangements for patients, staff, and visitors. Mitigate legal and regulatory risk, - ensuring compliance with the Regulatory Reform (Fire Safety) Order 2005 and NHS Firecode, preventing enforcement notices, prosecutions, or reputational harm. Improve estate resilience, - reducing the likelihood of fire-related service disruption, ward closures, or damage to critical clinical infrastructure. Strengthen organisational assurance, - providing the Board with confidence that fire safety across the estate is being effectively managed, monitored, and continuously improved.	Head Of Operational Estates	31/03/2030	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G5 Timely progression of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC	PBC Developments Ensure the HB has a strategic plan of major Capital Schemes which address Estates Safety such as Wrexham Maelor Continuity Plan – Phase and Ysbyty Gwynedd PBC Outcome A comprehensive, Board-approved strategic pipeline of major capital schemes is produced, ensuring that critical Estates Safety, infrastructure resilience, and service continuity risks across Wrexham Maelor and Ysbyty Gwynedd are clearly defined, prioritised, and supported by robust, compliant PBCs. This enables the HB to progress to SOC and subsequent business case stages with confidence, in alignment with WG capital requirements and timelines. Metric PBC Development & Approval - Review of Wrexham Maelor Continuity Plan PBC within agreed timeline. - Review of Ysbyty Gwynedd PBC within agreed timeline. Strategic Alignment & Quality - Compliance with WG Capital Guidance and Five-Case Model requirements. - Number of key risks and constraints captured and mitigations identified in PBCs. Impact on Risk Estates Safety Risk Reduction - High-risk backlog maintenance reduced through planned major capital interventions. - Clear identification and prioritisation of statutory and infrastructure compliance issues (e.g. fire safety, electrical resilience, water systems). - Enables proactive replacement of life-expired critical infrastructure (HV/LV, ventilation, medical gases, roofs, drainage etc.). Service Continuity & Resilience - Reduced risk of unplanned service outages at Wrexham Maelor and Ysbyty Gwynedd. - Improved resilience for essential acute and emergency services. - Lower likelihood of business continuity incidents due to infrastructure failure. Strategic & Financial Risk Reduction - Reduces risk of WG capital bids failing due to incomplete or misaligned business cases. Governance & Assurance - Improved transparency and auditability through structured PBC documentation. - Ensures HB meets statutory obligations for safe, sustainable estate provision.	Director of Environment and Estates	30/09/2026	Progressing Due date extended from 31/03/2026 to 30/09/2026 to reflect Foundations for the future structure
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G6 Assurance around the progress made with the BCUHB Estates Strategy and the lack of clarity around the BCUHB Clinical Strategy.	BCUHB Estates Strategy Progress with delivering an updated Estates Strategy by engagement with stakeholders across BCUHB and identifying a number of common themes around strategic ambitions for the estate that aligns with the Health Board's Clinical Strategy. Outcome Deliver meaningful progress on the Health Board's Estates Strategy by actively engaging with key stakeholders across BCUHB to identify shared priorities, establish common themes, and ensure that estates planning aligns directly with the Health Board's Clinical Strategy. This includes producing a clear, evidence-based strategic direction for the estate that supports clinical service transformation, improves functionality and resilience, and informs future investment decisions.	Director of Environment and Estates	30/09/2026	Progressing Revised date from 31/03/2026

	Metric Stakeholder Engagement Completion -Divisions, Clinical Boards, and Corporate Departments engaged as part of the Estates Strategy programme Themes & Strategic Priorities Identified - Number of common themes captured and validated across stakeholder groups (e.g., capacity, clinical adjacencies, digital enablement, estate condition, sustainability). Alignment with Clinical Strategy - Evidence of mapped alignment between Estates Strategy themes and the Health Board’s Clinical Strategy goals (target: full alignment across all major programmes). Strategic Output Deliver - Completion of key strategy documents (e.g., Strategic Outline Programme, Estate Development Priorities Schedule, site-specific masterplans) within agreed timescales Incorporation Into Planning & Capital Process - strategic priorities formally integrated into capital plans, business cases, or service transformation programmes. Impact on Risk Reduce strategic misalignment risk, ensuring estate development directly supports the Clinical Strategy rather than evolving in isolation. Mitigate investment and Financial risk (Capital and Revenue) by providing a clear, prioritised plan that supports informed capital decision-making and reduces the likelihood of unsuccessful business cases or inefficient expenditure. Lower operational and service delivery risk by identifying estate constraints early and planning improvements that enhance flow, capacity, and resilience across clinical environments. Improve organisational assurance, demonstrating that the Estates Directorate is actively engaging service leaders and shaping a modern, fit-for-purpose estate that supports safe, effective care. Reduce reputational and regulatory risk, ensuring that estate challenges—condition, compliance, functional suitability, sustainability—are addressed through a transparent and collaboratively developed long-term plan. Strengthen future readiness, ensuring the estate is aligned to changing service models, population health needs, digital transformation, and sustainability commitments.			

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G8 NWSSP Authorising Engineer – Water – Audit on water safety undertaken and agreed action developed to improve compliance which are reported at the Water Safety Group	Legionella Management and Control Ensure the Health Board is compliant with its statutory duty to manage water systems across the estate by addressing all fundings reported as part of the AE audit of water systems and operational management Outcome Achieve full statutory compliance in the management and control of Legionella across the Health Board estate by implementing all required actions identified in the Authorising Engineer (Water) audit. This includes ensuring safe operation, monitoring, testing, maintenance, and governance of water systems to minimise the risk of Legionella proliferation and protect patients, staff, and visitors. Metric: AE (Water) Audit Action Completion Rate - Audit actions completed within the agreed timeframe (target: 100%). Compliance score against ACoP L8 , - WHTM 04-01 Part B, and internal Water Safety Plan standards (target: full compliance or approved derogations in place). Legionella and Pseudomonas Sampling Compliance - Routine water sampling and microbiological monitoring completed on schedule. Impact on Risk Reduce the risk of Legionella growth , lowering the likelihood of Legionnaires’ disease outbreaks, safeguarding vulnerable patient groups and clinical operations. Mitigate statutory non-compliance , reducing exposure to enforcement action from regulators (HSE), legal claims, and reputational damage. Improve system reliability , ensuring cold and hot water systems remain within safe operating parameters. Strengthen organisational assurance through robust water safety governance, clear maintenance regimes, and evidence-based compliance reporting. Reduce operational disruptions , preventing ward closures, service interruptions, and emergency remedial works due to water safety failures.	Head Of Operational Estates	30/09/2026	Progressing Revised date from 31/03/2026

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis		
G9 NWSSP Authorising Engineer – Electrical– Audit on Electrical Systems undertaken and agreed action developed to improve compliance which are reported at the Electrical Safety Group	Electrical and Mechanical Infrastructure on the Wrexham Maelor Hospital Site Ensure the Health Board is compliant with its statutory duty to manage electrical systems across the estate by addressing all fundings reported as part of the AE audit of electrical systems and operational management Outcome Achieve full statutory compliance for electrical systems across the Wrexham Maelor Hospital site by implementing all required actions arising from the Authorising Engineer (AE) electrical audit. This includes ensuring safe operation, maintenance, resilience, and governance of electrical infrastructure, thereby supporting continuity of clinical services and reducing risk to patients, staff, and the organisation. Metric Statutory Compliance - Measured improvement against HTM 06-01 / BS 7671 compliance requirements (target: full compliance or approved derogations in place). Risk Reduction Achievement - Reduction in high- and medium-risk items recorded on the electrical risk register (target: 0 high risks, 50% reduction in medium risks within 12 months). Unplanned Outage Incidents - Year-on-year reduction in electrical infrastructure failures or unplanned interruptions impacting clinical services (target: continual reduction). Impact on Risk Significantly reduce risks associated with electrical system failure , including power loss to critical clinical areas, unsafe equipment operation, or potential electrical fires. Mitigate organisational statutory non-compliance risk , preventing enforcement action, regulatory escalation, or reputational harm. Improve resilience of electrical infrastructure , reducing vulnerability during peak clinical load, emergency events, or equipment failure. Lower health and safety risks to patients, staff, and contractors through improved control of isolation, testing, and operational procedures. Strengthen assurance to the Board , demonstrating that the Estates function is effectively managing safety-critical infrastructure in line with HTMs, legislation, and AE recommendations.	Head Of Operational Estates	31/03/2028	Progressing		
				Impact	Likelihood	Score
		Inherent Risk Rating		4	5	20
		Current Risk Rating		4	5	20
		Target Risk Score		3	4	12
		Risk Appetite		Regulatory/Compliance <15	Not in Tolerance	
Position & Intended Outcome for Risk						
Current Risk score of 20 aims to be reduced to a 12 by April 2035 as a part of a wider Estates strategy. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties were £348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog. The estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board. To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a partial facet survey for the Estates, these surveys will commence in 2026 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estate's portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10-year capital investment requests align with the capital prioritisation form that we will submit to Welsh Government.						

In addition, significant works have been undertaken on the fire project at Ysbyty Gwynedd which will result in approx £2M being invested and works completed by March 2026. Wrexham Resilience Programme has undertaken a risk-based approach to address key findings of the original Business Case. The Health Board has disposed of 2 sites (Ala Road and Cilan) this financial year which were vacated as 'not being fit for purpose', approval has also been received to dispose of Rossett HC and Ruthin HC which have been vacated due to condition of the Estate and these are expected to progress to auction in early 2025. Both sites are currently being disposed of with Ruthin HC awaiting completion of contract.

[Internal Audit review of Asbestos Management has been completed which reported Substantial Assurance, due to this outcome action G7 'Internal Audit review of Asbestos Management – Agreed Management Action Plan developed and managed through the Asbestos Management Group' has been completed.](#)

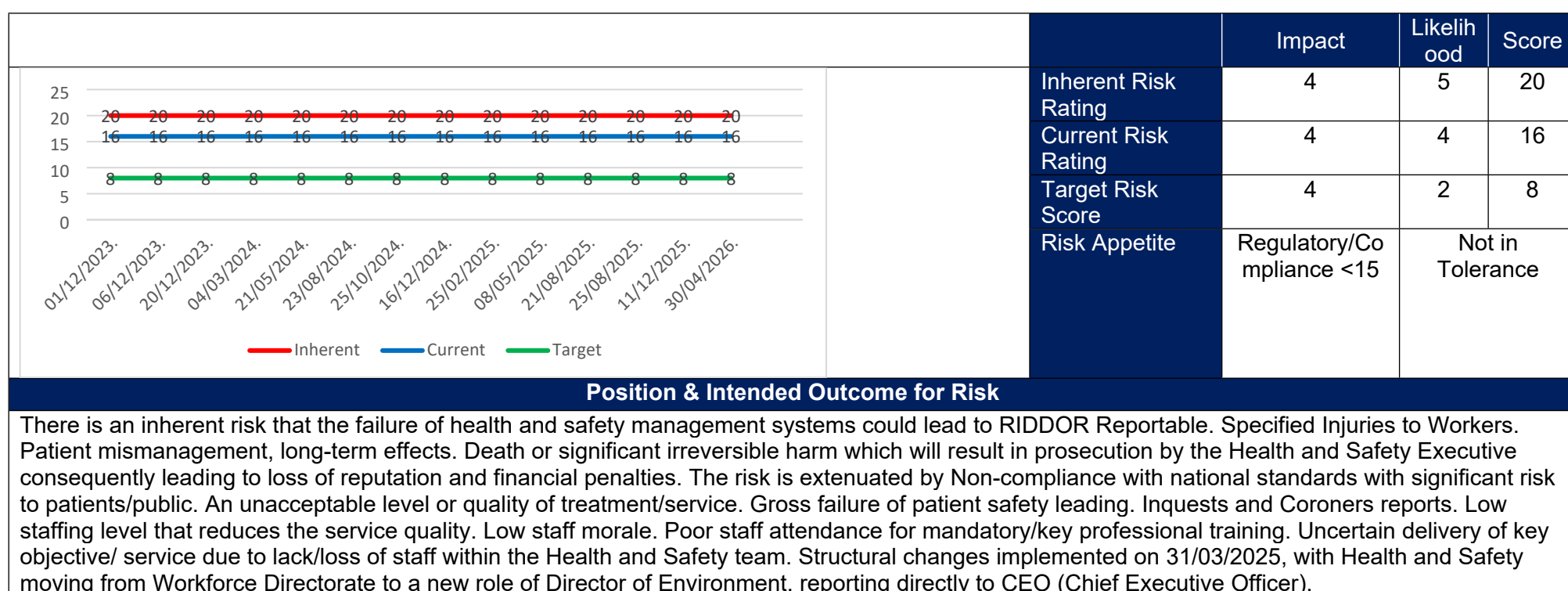
[Estates Rationalisation programme being reviewed to identify any quick wins that can deliver financial savings quicker.](#)

CRR REF: 25-10: Risk Title: Health and Safety		
Director Lead: Director of Environment and Estates (DoE&E)		Date Opened: 21/08/2025
Assuring Committee: Performance, Finance and Information Governance Committee		Date Last Committee Review: 24/02/2026
Date Last Reviewed: 30/04/2026	Link to BAF: BAF24-03	Target Risk Date: 31/03/2027
Risk Detail: There is a risk that the organisation may fail to maintain a safe environment for staff, patients, service users and visitors in line with health and safety legislation. This may be caused by • Inadequate governance, leadership oversight or assurance of health and safety arrangements. • Insufficient resources (financial, staffing or time) allocated to health and safety management. • Poor compliance with statutory inspections, maintenance schedules or risk assessments. • Lack of staff competence, training or awareness of health and safety responsibilities. • Failure to learn from incidents, near misses or external safety alerts. • Ageing estate, infrastructure failures or unsafe plant and equipment. • Inconsistent application of policies and procedures across sites or services. This may lead to • Injury, ill-health or fatalities involving staff, patients or visitors. • Increased incidents, near misses and reportable accidents (RIDDOR). • Regulatory enforcement action (e.g. HSE or CQC notices, prosecutions or fines). • Civil claims, increased insurance costs and reputational damage. • Reduced staff morale, increased sickness absence and staff turnover. • Service disruption, ward closures or loss of public confidence. • Failure to meet statutory duties and corporate objectives.		
Mitigations/Controls in place		
Governance and Leadership (Links to ACR1) • HS01 Health and Safety Policy approved and reviewed at Board level • Director of Environment and Estates Designated Executive Lead for Health and Safety • Health and Safety Committee (Strategic Occupational Safety and Health Group) with staff side representation, which escalates up to People and Culture Committee. Health and Safety Risk Management (Links to ACR2) • Annual gap analysis using the NHS Employer Health and Safety Standards used to assess compliance against current health and safety legislation and standards • HS03 General Risk Assessment Procedure • Local Health and Safety File • Routine workplace risk assessments (e.g. slips and trips, manual handling, COSHH, etc.) • Incident reporting systems and investigation processes Training and Competence (Links to ACR3) • Mandatory health and safety training for all staff • Accredited Health and Safety Training courses (e.g. NEBOSH) • In-house taught Health and Safety Training courses (e.g. Risk Assessment, COSHH, RIDDOR) • Health and Safety webpages on BetsiNet Monitoring and Assurance (Links to ACR4&5) • Proactive: Scheduled health and safety reviews/audits that incorporate workplace inspection • Reactive: Ad hoc visits in response to incidents		

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1a A review of resources required following the internal audit	A review of resources within the Health, Safety and Security Service is required following the internal audit findings. Produce a documented resource review paper and proposed structure for Leadership consideration. Complete a business case if necessary ready for approval. Initial structure review and remodelling completed; progress dependent on the outcome of the Foundations for the Future program, which will inform final decisions. Addresses audit recommendations to ensure adequate resourcing and supports delivery of Health and Safety objectives across BCUHB. Complete the resource review and business case by September 2026, following confirmation of Foundations for the Future outcomes. Outcome An appropriately resourced Health, Safety and Security Service that meets internal audit recommendations and supports statutory compliance across BCUHB. Metric • Resource review paper and proposed structure completed by September 2026. • Business case (if required) completed and submitted for approval by November 2026. • Final structure aligned with outcomes of the Foundations for the Future programme. Impact on Risk Completing the review and securing the required resources will reduce the likelihood of non-compliance, improve assurance, and strengthen organisational safety governance.	DoE&E	31/03/2027	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR1b A review of the Terms of Reference, Cycle of Business and Escalation and De-escalation Routes	Undertake a comprehensive review and update of the Terms of Reference, Cycle of Business, and escalation and de-escalation routes to ensure clarity of roles, responsibilities, decision-making authority and timely escalation of health and safety risks. Outcome Clear, consistent and well-understood governance arrangements that support effective oversight, assurance and timely management of health and safety risks at all levels of the organisation. Metric • Revised Terms of Reference, Cycle of Business and escalation framework formally approved • Evidence of dissemination and staff awareness • Auditable compliance with escalation timescales and reporting routes • Reduction in delayed or inappropriate escalations identified through reviews or audits Impact on Risk Improves governance and assurance, reducing the likelihood of unmanaged or unrecognised health and safety risks, and lowering the overall risk of failing to maintain a safe environment for staff and patients.	DoE&E	31/03/2027	Progressing
ACR2: Health and Safety Risk Management (DO)				
ACR2a Review of HS03 General Risk Assessment Procedure	Undertake a review and update of the HS03 General Risk Assessment Procedure to ensure it remains current, legally compliant, clearly articulated and consistently applied across all services and sites. Outcome A robust, clear and standardised risk assessment procedure that supports effective identification, evaluation and control of health and safety risks and promotes consistent practice across the organisation. Metric • HS03 procedure formally reviewed, updated and approved • Evidence of implementation and dissemination to managers and staff • Increased compliance identified through audits and assurance reports • Improved quality and consistency of risk assessments reviewed	Head of Health, Safety and Security	31/03/2027	To commence

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
	Impact on Risk Reduces the likelihood of poorly identified or inadequately controlled hazards, strengthening organisational compliance with health and safety legislation and lowering the overall risk of harm to staff and patients.			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR2b Implement an Electronic Document Management System (EDMS) across BCUHB to centralise health and safety compliance reporting and house risk management documentation, to support a health and safety management framework	Source or develop and implement a digital technology solution to support the health and safety risk management framework, enabling consistent recording, monitoring, escalation and assurance of risks, actions and controls across the organisation. Outcome A single, reliable and transparent system that improves the visibility, consistency and timeliness of health and safety risk management, supporting informed decision-making and effective organisational assurance. Metric - Technology solution procured/developed and fully implemented - Percentage of services using the system for health and safety risk management - Improved completeness, timeliness and quality of risk and action data - Reduction in manual processes and duplicated reporting Impact on Risk Strengthens risk identification, monitoring and escalation, reducing the likelihood of unmanaged or poorly controlled health and safety risks and improving the organisation's ability to maintain a safe environment for staff and patients.	Head of Health, Safety and Security	31/03/27	To commence
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
ACR2c Reviewing and updating the Health and Safety Risk Assessment Training Course	Review, update and re-launch the Health and Safety Risk Assessment Training Course to ensure it reflects current legislation, organisational procedures and best practice, and is accessible to all staff with health and safety responsibilities. Outcome Improved staff knowledge, competence and confidence in completing suitable and sufficient health and safety risk assessments, leading to more consistent and effective risk control across the organisation. Metric - Updated training course approved and implemented - Percentage of relevant staff completing the updated training - Improved quality of risk assessments identified through audit and review - Reduction in errors, omissions or repeat findings linked to risk assessments Impact on Risk Reduces the likelihood of hazards being poorly identified or inadequately controlled by improving workforce competence, thereby lowering the overall risk of harm to staff and patients and improving compliance with health and safety legislation.	Head of Health, Safety and Security	31/03/2027	To commence
ACR3: Training and Competence (DO)				
G3a A pan BCUHB Health, Safety and Security Training Needs Analysis is required.	Health, Safety and Security Training Needs Analysis under development. Outcome A comprehensive, pan-BCUHB Health, Safety and Security Training Needs Analysis that clearly identifies statutory, mandatory, role-specific and risk-based training requirements across the organisation. The completed TNA will provide a clear framework for training provision, resource planning and compliance monitoring, ensuring consistent and appropriate training delivery across all services. Metric - Approval of the TNA by relevant governance groups (e.g., SOSHG and Executive Committee). - Identification of training gaps and development of an implementation or delivery plan. - Measurable improvements in training compliance rates across Health, Safety and Security subjects.	Head of Health, Safety and Security	31/12/2026	Progressing

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
	Reduction in variation of training requirements or delivery between Divisions. Impact on Risk A robust, organisation-wide TNA reduces the risk of non-compliance with statutory and mandatory training requirements, improves clarity for managers and staff, and supports safer practice across the organisation.			
G3b BCUHB Executive Team and Board of Directors to complete health and safety training.	NEBOSH HSE Certificate in Health and Safety Leadership Excellence 1-day accredited course. Outcome Executive Team and Board members will have the required level of Health and Safety knowledge and assurance to fulfil their statutory duties, demonstrate effective organisational oversight, and meet internal audit expectations. Metric - Agreement of the proposal by the Director of Estates and Director of Governance. - Approval and scheduling of the training programme. 100% completion of the required Health and Safety training by Executive Team and Board members within the agreed timeframe. Impact on Risk Completing Health and Safety training for Executive and Board members will enhance understanding at senior levels reduces risks relating to poor decision-making, inadequate oversight, regulatory non-compliance, and potential enforcement action.	DoE&E	31/03/2027	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G3c Intranet pages for Health, Safety and Security Services require development.	Outcome A comprehensive, accessible and up-to-date Health, Safety and Security intranet site aligned to the NHS Employer Health and Safety Standards that provides staff with clear guidance, policies, procedures, training information and support resources. The developed intranet pages will improve organisational visibility, enhance staff access to essential information, and support consistent practice across BCUHB. Metrics - Increased staff access and usage (measured via intranet analytics, where available). - Reduction in staff queries related to information that is now accessible online. Impact of Risk Improved access to accurate and current Health, Safety and Security information reduces the likelihood of procedural errors, non-compliance, and inconsistent practice. Clear guidance supports safer working environments, reduces the risk of incidents, strengthens organisational assurance, and improves staff confidence in accessing essential safety information.	Head of Health, Safety and Security	31/03/27	Progressing



Additional Controls required	Action	Action Owner	Due Date	Progression Analysis
ACR1: Governance and Leadership (PLAN)				
ACR1c Determine the Organisations H&S policy/Plan for implementation: Review of health and safety policies within the next 12-24 months.	Policy tracker presented to SOSHG quarterly and updates specific to Policies provided to Executive Policy Oversight Group, with further oversight by Policy and Compliance Team. Outcome A fully reviewed, up-to-date, and compliant suite of Health and Safety policies that reflect current legislation, national guidance, internal audit expectations, and organisational requirements. The policy tracker provides structured oversight and assurance to SOSHG, ensuring visibility of progress and governance throughout the review cycle. Metric - Regular updates of the policy tracker and presentation to SOSHG. - Reduction in overdue policies or those requiring exception reporting. Impact on Risk Timely review and updating of health and safety policies reduces the likelihood of non-compliance with statutory requirements, inconsistent practice across the organisation, and potential legal or regulatory challenge. Up-to-date policies strengthen governance, provide clarity for staff, and ensure that safe systems of work are based on current, accurate guidance.	DoE&E	28/04/27	Complete
ACR2: Health and Safety Risk Management (DO)				
ACR2a A Health and Safety Management Framework needs developing.	Develop a Health Board Health and Safety Management Framework. The introduction of the NHS Employer's Health and Safety Standards will provide an indication of Health & Safety performance and be a mechanism to monitor the Health Board Health & Safety management framework and will be used to formulate strategy moving forwards. Key service objectives will be monitored going forward. Standards and guidance are available; resources and stakeholder engagement will be secured through the Health & Safety governance structure. Supports compliance, improves governance, and provides a structured mechanism for monitoring and continuous improvement of health and safety performance. Framework to be developed, approved, and implemented by April 2025 with first performance report issued by June 2025. This is complete. The standards are in use and the Health and Safety Team are completing the second Cohort of the self-assessment exercise that this action is built around. Paper went to Executive Committee 12/11/2025 and People and Culture Committee 04/12/2025.	Head of Health, Safety & Security	31/12/25	Complete
ACR4&5: Governance and Leadership (PLAN)				
ACR4&5 A Health and Safety Management Framework needs developing.	A process to monitor and review department self-assessments is under development and will be issued in readiness for the April Self-Assessment Cycle. Complete see action point 1 above and the paper that went to EC (Executive Committee) and P&CC (People & Culture Committee)	Director of Estates	31/12/25	Complete

Audit Committee

BOARD ASSURANCE FRAMEWORK 2026-2027

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Jody Evans Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol **Executive Summary**

The refreshed Board Assurance Framework (BAF) has been developed to align with the Health Board's revised Strategic Intentions, and currently comprises four principal strategic risks, with a fifth risk relating to long-term financial sustainability undergoing Executive Director review and validation.

BAF Risk Reference	Strategic Intent	Principal Strategic Risk
BAF 26/01	Population Health and Reducing Inequalities	Failure to deliver improved population health and reduce inequalities.
BAF 26/02	Coordinated Care for Long-Term Conditions and Community Services	Failure to deliver enhanced coordination of care for people with long-term conditions and improve access.
BAF 26/03	Access, Outcomes and Experience	Failure to improve access, outcomes and experience.
BAF 26/04	Creating a Modern, People-Centred and Future-Focused Healthcare System	Failure to deliver a modern, people-centred healthcare system that is future-focused.
BAF 26/05	Cross-cutting Organisational Risk	Failure to achieve long-term financial sustainability.

The emerging assurance position across the Framework is predominantly one of Limited Assurance. This reflects that assurance is currently derived primarily from

evidence of activity, programme delivery and governance arrangements, with more limited evidence demonstrating measurable outcomes, sustainable improvement and reduction in strategic risk exposure.

BAF Risks 26/01, 26/02 and 26/03 have been completed, validated and uploaded to the Portal. BAF Risks 26/04 and 26/05 **remain subject to Executive Director validation** and the assurance position for these risks should therefore be regarded as provisional.

The principal assurance gaps identified relate to outcome-based measures, benefits realisation, independent sources of assurance and evidence of sustained risk reduction. These gaps currently limit the level of assurance available to the Board regarding the effectiveness of controls and delivery of strategic objectives. Governance oversight will be strengthened through scrutiny by Executive Committee, Board Committees and Board, supported by future AAA reporting which will facilitate triangulation of assurance, performance and risk information.

Audit Committee is asked to:

- **NOTE** the emerging assurance position within the refreshed BAF.
- **SCRUTINISE** the identified assurance gaps and their implications for Board assurance.
- **ENDORSE** the actions required to complete validation of BAF Risks 26/04 and 26/05.
- **SUPPORT** ongoing development of assurance arrangements and reporting mechanisms.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	29 July 2026	Draft BAF discussed for onwards reporting and validation.
Risk Scrutiny Group	20 July 2026	Draft BAF reviewed and endorsed subject to completion of outstanding Executive Director feedback and amendments.
Executive / Directors	June – July 2026	Draft BAF risks circulated for review, challenge and validation.
Transformation and Improvement Team	Ongoing	Collaboration continuing to develop the BAF within the Portal and explore future reporting integration opportunities.

Acronymau / Rhestr Termau
Acronyms / Glossary of Terms

BAF	Board Assurance Framework
IMTP	Integrated Medium Term Plan
ADP	Annual Delivery Plan
EC	Executive Committee

BOARD ASSURANCE FRAMEWORK 2026-2027

1. Y SEFYLLFA SITUATION

To provide Audit Committee with the emerging assurance position across the refreshed Board Assurance Framework, including the current assurance ratings, assurance gaps, areas of limited assurance and the implications for Board assurance. The report also highlights matters requiring ongoing scrutiny to strengthen assurance and support effective oversight of strategic risks.

The Board Assurance Framework has been refreshed to reflect the revised Strategic Intentions within the IMTP and to strengthen strategic risk oversight across the organisation. The refresh aims to provide a clear line of sight between strategic objectives, delivery plans, operational performance and Board assurance.

Subject to completion of the remaining Executive Director validation activity during August 2026, the refreshed Board Assurance Framework will be incorporated into the Committee reporting cycle from August 2026 and formally reported through Board arrangements from September 2026.

2. Y CEFNDIR BACKGROUND

The BAF 2025/26, approved by the Board in May 2026, was developed against the earlier strategic framework and required review following approval of the refreshed IMTP. A programme of work has therefore been undertaken to review the existing BAF structure, map outstanding actions from the previous BAF, develop principal strategic risks aligned to the revised Strategic Intentions, and identify associated threats, controls, assurances and mitigating actions.

The refresh has also sought to align mitigating actions with Annual Delivery Plan deliverables, strengthen Executive Director ownership of strategic risks, and develop reporting arrangements within the Portal.

3. MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

The Committee is asked to consider whether the assurance arrangements supporting the Board Assurance Framework provide sufficient confidence regarding delivery of the Health Board's strategic objectives. Particular consideration should be given to the robustness of assurance sources, the appropriateness of assurance ratings and the significance of identified assurance gaps.

The Audit Committee is asked to note:

- **The progress** made in developing the refreshed Board Assurance Framework across the four Strategic Intent, including the identification of principal risks, controls, sources of assurance, assurance gaps and mitigating actions.
- **The current status** of each of the principal BAF risks and the emerging assurance position, noting that further work is required to strengthen outcome-based assurance and consistency of reporting across the framework.
- **The need for timely completion** of the outstanding Executive Director validation of BAF Principle Risks 04 and 05 and relevant priorities, which remains the key dependency to finalising the refreshed Board Assurance Framework and implementing the planned reporting cycle.
- **The reporting arrangements** through Executive Committee, Board Committees and Board, designed to strengthen ownership, oversight and monitoring of strategic risks across the organisation.
- **The need to further strengthen** assurance arrangements through development of outcome-focused measures, benefits realisation reporting and independent assurance sources.

Cross Cutting Assurance Themes:

The refreshed Board Assurance Framework has identified a number of recurring themes across the Strategic Intent:

- Predominance of Limited Assurance ratings across strategic risks.
- Strong evidence of activity, programme delivery and governance arrangements.
- Limited evidence demonstrating measurable outcomes and sustained impact.
- Greater focus required on benefits realisation and outcome based reporting.
- Limited availability of independent sources of assurance in some areas.
- Further work required to demonstrate sustained risk reduction over time.

Assurance Gaps

The principal assurance gaps identified through the Board Assurance Framework refresh are:

- Limited outcome based measures demonstrating that controls are reducing strategic risk.
- Inconsistent evidence of benefits realisation across strategic programmes.
- Reliance on management assurances with fewer independent sources of assurance.

- Limited evidence demonstrating sustained improvement over time.
- Variation in assurance maturity across the Strategic Intent.

These gaps do not indicate a lack of activity. However, they limit the level of assurance currently available to the Board regarding the effectiveness of controls and the extent of risk reduction being achieved.

These themes will inform future development of the BAF and reporting arrangements to support stronger Board assurance and strategic oversight.

4. Governance Oversight

As the refreshed Board Assurance Framework becomes embedded, governance oversight will be strengthened through scrutiny by Executive Committee, Board Committees and the Board. Regular review of strategic risks, assurance ratings, assurance gaps and mitigating actions will support greater ownership and accountability across the organisation.

Future AAA reporting will support triangulation of assurance, performance and risk information, enabling improved scrutiny of whether strategic risks are reducing and whether intended outcomes are being achieved.

5. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

A number of matters require continued oversight to ensure the refreshed Board Assurance Framework (BAF) is fully implemented and embedded. Whilst the outstanding Executive Director validation of BAF Risks 26/04 and 26/05 remains a key dependency to finalising the framework, the more significant issue for the Board is the emerging assurance position across the strategic risks.

The refreshed BAF identifies a predominance of Limited Assurance ratings, reflecting that assurance is currently derived largely from evidence of activity, governance arrangements and programme delivery, rather than demonstrable evidence of outcomes, impact and sustained risk reduction. Key assurance gaps relate to outcome measurement, benefits realisation and the availability of independent assurance. As a result, assurance remains focused more on evidence of activity than demonstrable impact and risk reduction.

The effectiveness of the refreshed BAF will also depend on the quality and consistency of assurance provided through Board Committees. As the framework becomes embedded, further work will be required to strengthen alignment between Strategic Intent, principal risks, Committee responsibilities and AAA reporting to ensure the Board receives robust and reliable assurance on the management of strategic risks.

There is also a need to ensure that strategic risks remain aligned with the Health Board's changing priorities and operating environment, including Clinical Services Planning, Foundations for the Future, Special Measures requirements and wider financial and policy pressures. Without regular review, there is a risk that the BAF may not continue to reflect the most significant risks to delivery of the Health Board's strategic objectives.

These matters do not prevent implementation of the refreshed BAF; however, they highlight areas where further development is required to strengthen Board-level assurance and support a progressive move from a predominantly Limited Assurance position towards increased assurance over time.

6. ARGYMHELLION RECOMMENDATIONS

a. Gofynnir i'r Pwyllgor
The Committee is asked to:

- **NOTE** the emerging assurance position across the refreshed Board Assurance Framework, recognising that the majority of strategic risks currently attract Limited Assurance ratings.
- **SCRUTINISE** the key assurance gaps identified within the Framework, particularly those relating to outcome measures, benefits realisation and independent assurance.
- **ENDORSE** the actions required to complete Executive Director validation of BAF Risks 04 and 05 and support finalisation of the Framework.
- **SUPPORT** the continued development of assurance arrangements and reporting mechanisms to strengthen Board assurance and strategic oversight.

Appendices:

- Appendix 1 – BAF
- Appendix 2 – Mapped Open Actions from Extant BAF 2024-2025 for information.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	Choose an item.
Link to Strategic Intentions	If more than one applies, please list below: All apply.
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	This paper relates directly to the Board Assurance Framework and supports the Health Board's strategic risk management arrangements through the development and implementation of a refreshed BAF aligned to the IMTP.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report.
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report.
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	No
	Os naddo, dylech gynnwys y rheswm:	N/A

	If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative Report
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ Administrative report
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Administrative report.

	If more than one applies, please list below:	
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act –</u> <u>Wellbeing Goals</u>	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list below:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Administrative report.
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below)	
	Positive impact through improved Board oversight, assurance and transparency regarding strategic risk management.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	Existing resources have been utilised to undertake the BAF refresh. Future efficiencies are anticipated through integration with Portal reporting	

	arrangements and alignment with ADP reporting processes.

Board Assurance Framework 2026-29



Board Assurance Framework

The Board Assurance Framework (BAF) provides a single view of the organisation's principal risks, how they are being managed, and the level of assurance available to the Board. It brings together strategic risks, controls, actions and assurance sources to support effective oversight and decision-making.

Pending Action

33

Plans Pending Update

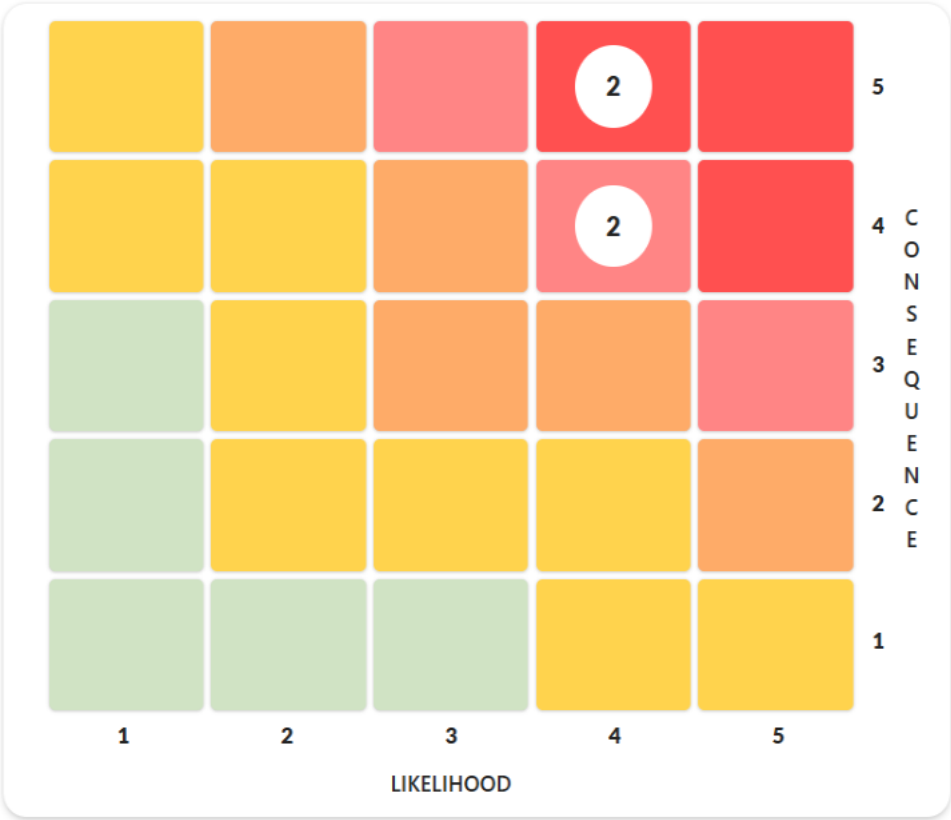
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Threats Pending Update

0

BAF Risks Pending Update

All Risks		Reset All Risks
Risk Title	Current Score	
BAF26-03 - Failure to Improve access, outcomes and experience	20	
BAF26-04 - Failure to deliver and create a modern, people centred health care system that is future focused	20	
BAF26-01 - Failure to deliver improved population health and reduced inequalities	16	
BAF26-02 - Failure to deliver enhanced coordination of care for people with long term conditions and improve access	16	
BAF26-05 - Failure to achieve long-term financial sustainability		



BAF26-01

Failure to deliver improved
population health and
reduced inequalities

Current
Risk Score

16



9

Target Risk
Score

Threats

4

Plans:

Complete:

1

In Progress:

32

Overdue:

0

BAF26-02

Failure to deliver enhanced
coordination of care for people
with long term conditions and
improve access

16



12

3

1

25

3

BAF26-03

Failure to Improve access,
outcomes and experience

20



15

9

14

76

3

BAF26-04

Failure to deliver and create a
modern, people centred health
care system that is future
focused

20



15

11

17

75

9

BAF26-05

Failure to achieve long-term
financial sustainability



0

0

0

0

Key to lead committee assurance ratings:



Substantial Assurance

The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.



Reasonable Assurance

The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed.



Limited Assurance

Likelihood of risk materialising: Low to moderate.

The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.



Unsatisfactory Assurance

The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High



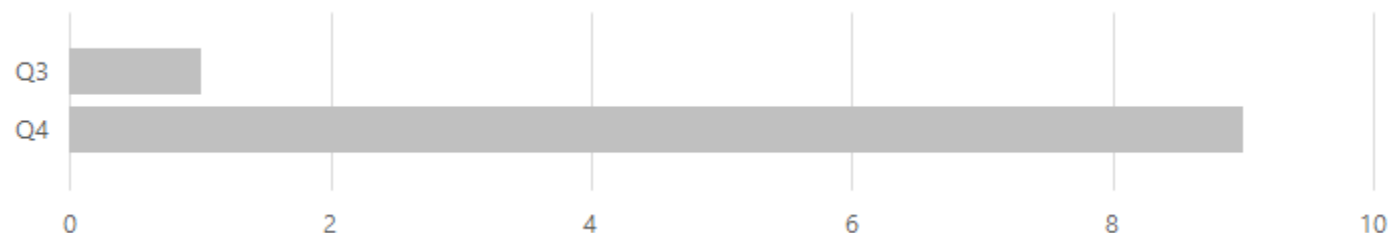
1

Focus on Health and Wellbeing through every stage of life – enabling a greater emphasis on, and increased development and delivery of preventative, proactive strategies, working with partners rooted in communities.

Principal risk (What could prevent us achieving this strategic objective)	BAF 26 01 - Failure to deliver improved population health and reduced inequalities There is a risk that the Health Board fails to improve population health and reduce inequalities, due to insufficient progress in prevention and early intervention, leading to increased demand, widening inequalities, and pressure on acute services.			
Lead Commitee	Planning, Population Health & Partnerships Committee		Risk Type	Quality
Risk Lead	Executive Director of Public Health		Risk Appetite	<15
Related Corporate Risks:	CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce, CRR25-03 – Population Needs, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability			
Risk Rating			Review Dates	
	Current Exposure	Target		
Consequence	4	3	Initial assessment	July 2026
Likelihood	4	3	Last Committee review	
Risk Rating	16	9	Last Executive Review	July 2026

Priority:	1A Preventative approaches to Health & Wellbeing				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to improve population health and wellbeing due to increasing prevalence of preventable long term conditions, insufficient uptake of preventative interventions, and limited impact of early intervention programmes, leading to increased demand on acute and community services and widening health inequalities.					
Accountable:	Executive Director of Public Health				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Delivery of Healthy Weight programmes (children and adults) • Implementation of Weight Management Review recommendations • Delivery of grant funded prevention programmes • Development of Health Improvement offer across the system • Delivery of early years and school-based prevention interventions • Embedding Making Every Contact Count (MECC) training • Partnership working with: - Public Service Boards - PSBs) - Local Authorities - Third Sector		G1: Limited scale and impact of preventative interventions across the population G2: Workforce capability and capacity to plan for and deliver prevention consistently (e.g. MECC undertaken by patient facing staff) G3: Increasing prevalence of obesity and lifestyle-related conditions G4: Limited intelligence to fully target prevention activity G5: Population Health improvement is dependent on whole system approach	Management Assurance IMTP monitoring of 1A.1–1A.10 deliverables Performance metrics: • Smoking cessation targets • Access to weight management services and healthy weight • Improved Breastfeeding rates • Number of staff completing MECC training Programme governance (Health Improvement / Public Health programmes) Risk & Compliance Assurance Alignment to: • National Public Health strategies • Weight Management Review recommendations • National Mental Health & Wellbeing Strategy • Internal programme reviews Independent Assurance • Welsh Government oversight • Public Health Wales reporting (grants) • Public Health Outcomes Framework	A1: Limited assurance of long-term behaviour change outcomes A2: Limited independent validation of impact of prevention programmes A3: Data limitations on prevention and early intervention impact A4: Limited real-time evidence linking interventions to reduced demand A5: Limited assurance on reduction of inequalities at pace A6: Limited assurance on workforce consistency and capability	

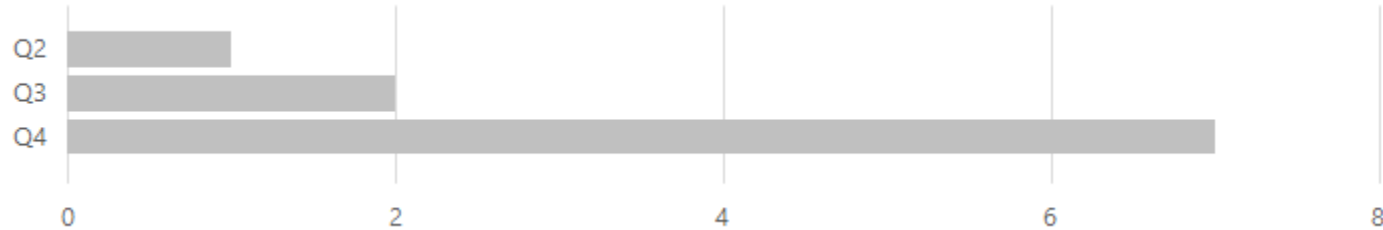
Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1A.1	Develop a proposal to support referrals to appropriate support following participation in Child Measurement Programme (e.g. to CAMHS, Children's, Dietetics, Weight Management).	G1 G3 G4	A1 A4	Executive Director of Public Health	Q3 (No Update provided during this reporting cycle)
1A.2	Implementation of the recommendations in the Weight Management Review, increasing activity in Level 2 Adult weight services.	G1 G3 G4	A1 A5	Executive Director of Public Health	Q4 (Moderate Delivery Confidence)
1A.3	Deliver approved Grant funded Programmes of work (Prevention and Early Years, Whole School Approach, Whole System approach to Healthy Weight)	G1 G5	A4 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1A.4	Provide education and targeted approaches to healthy choices through supporting schools, early years environments and families through Dietetics - early years programmes (Come & Cook, Tiny Tums).	G1 G3	A1 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1A.5	Act on the conditions that influence risk factors for ill-health (e.g. environmental, social or economic interventions), including promoting a state of good	G3 G5	A4 A5	Executive Director of Public Health	Q4 High Delivery Confidence

	mental and physical health through assessment of impact including: 1) influence planning applications 2) work with the Alcohol Partnership Board and Public Service Boards (PSBs) to implement their plans 3) contribute to developing the environment through local development plans and Actif North Wales to consider green and blue spaces.				
1A.6	Agree and commence a phased implementation of an enhanced Health Improvement offer within the Health Board and with partners across the health system that increases access to evidence-based opportunities to improve health and wellbeing outcomes.	G1 G5	A1 A4 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1A.7	Produce gap analysis and opportunities from the potential and current state to shape the enhanced Health Improvement offer for services.	G4	A3 A4	Executive Director of Public Health	Q4 High Delivery Confidence
1A.8	Embed Health Improvement into the following areas: 1) delivery planning to support Statement 2 & 4 of the National Mental Health & Wellbeing Strategy (led by Mental Health Services / Public Health Wales), 2) refresh the Preconception Strategic Plan, 3) response plan developed from the weight management review recommendations.	G1 G2	A1 A6	Executive Director of Public Health	Q4 High Delivery Confidence
1A.9	Healthy Travel Charter – increase the number of participating organisations each quarter, supporting Public Service Boards (PSBs) and wider partners to register organisational commitment at a regional and national level.	G5	A5	Executive Director of Public Health	Q4 High Delivery Confidence
1A.10	Embed Making Every Contact Count (MECC) brief intervention training into organisational processes to increase numbers of trained staff.	G2	A6	Executive Director of Public Health	Q4 (Moderate Delivery Confidence)

Priority:	1B Proactive strategies for disease prevention, falls & frailty				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to reduce the prevalence and impact of disease, falls and frailty due to increasing demand from an ageing population, variation in clinical outcomes (e.g. diabetes), insufficient uptake of screening programmes, and limited use of population health intelligence, leading to avoidable deterioration in health outcomes, increased service demand, and widening health inequalities.					
Accountable:	Executive Director of Public Health				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Delivery of Diabetes High Value High Impact pathway (1B.4) • Development and implementation of Population Health Management (PHM) programme (1B.1–1B.3) • Delivery of screening improvement plans and uptake initiatives (1B.8–1B.10) • Improvement programmes to reduce variation in diabetes care processes (1B.6–1B.7) • Place-based care models through Primary and Community Care (1B.5) • Partnership working with Public Health Wales and national screening programmes • Performance monitoring against diabetes and screening indicators		G1: Limited maturity and implementation of Population Health Management (PHM) approach G2: Variation in clinical performance and outcomes (e.g. diabetes care processes) G3: Insufficient uptake and variation in screening programmes G4: Limited early identification and targeting of at-risk populations G5: Increasing demand from ageing population (frailty and long-term conditions) G6: Limited integration of data across systems to support proactive care	Management Assurance IMTP monitoring of 1B deliverables (1B.1–1B.10) - Performance indicators: Diabetes care processes and screening metrics - Programme governance arrangements Risk & Compliance Assurance - Alignment to national diabetes and screening standards - Internal reviews and compliance checks Independent Assurance - Welsh Government oversight - Public Health Outcomes Framework	A1: Limited assurance of long-term impact of disease prevention and frailty reduction A2: Limited independent validation of effectiveness of PHM interventions A3: Data limitations impacting ability to track outcomes at population level A4: Limited real-time linkage between preventative action and reduced demand A5: Limited assurance on reduction of variation in clinical outcomes A6: Limited evidence of sustained improvement in screening uptake	

Plans to improve control :	
	

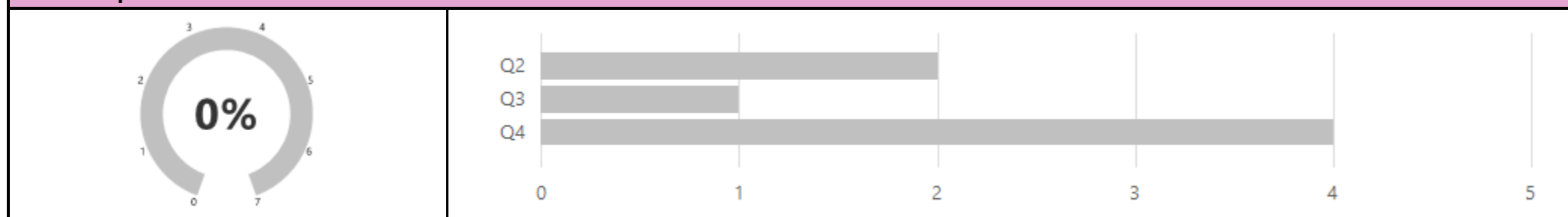
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1B.1	Develop and agree a comprehensive road map that outlines priorities, roles, data requirements and phased delivery actions to support the development of the Population Health Management (PHM) Programme.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	Q3 High Delivery Confidence
1B.2	Develop and launch a suite of health intelligence resources that support improved, evidence-based decision-making in service planning and help identify and reduce inequalities.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	Q2 High Delivery Confidence
1B.3	Establish a Population Health Management (PHM) programme with the Digital Team (DDAT) through development of a comprehensive road map, that will facilitate sustainable healthcare transformation in future years by targeting interventions that prevent ill health, improve care and support for people with ongoing health conditions, and reduce inequalities in health outcomes.	G1 G2 G3 G4 G5 G6	A1 A2 A3 A4 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1B.4	Complete implementation of the focused Diabetes High Value High Impact pathway.	G2 G4 G5	A5	Executive Director of Public Health	Q4 High Delivery Confidence
1B.5	Identify place-based approaches within Primary and Community care and develop options which respond to population need and deliver holistic patient centred care for people living with diabetes.	G2 G4 G5	A1 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1B.6	Support improvement and reduce variation in performance and compliance in relation to Diabetes priorities including: 8 Care Processes and reducing variation.	G2 G4 G5 G6	A5	Executive Director of Public Health	Q4 High Delivery Confidence
1B.7	Implement appropriate best practice within the national Quality Statement for Diabetes.	G2	A5	Executive Director of Public Health	Q4

					High Delivery Confidence
1B.8	Support the introduction of the National Lung Screening Programme (commence 2027).	G3 G4 G5	A6	Executive Director of Public Health	Q4 High Delivery Confidence
1B.9	Create a plan together with Public Health Wales to support delivery of the National screening uptake targets and improvement against National performance indicators and to reduce variation.	G3 G4	A5 A6	Executive Director of Public Health	Q4 High Delivery Confidence
1B.10	Produce local plans to support new National Public Health Wales Human Papillomavirus (HPV) self-sampling programme.	G3	A6	Executive Director of Public Health	Q3 (Moderate Delivery Confidence)

Priority:	1C Health Inequalities				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to reduce health inequalities due to insufficient partner commitment to the Prevention, Anchor and Wellbeing Framework, and continued variation between the most and least deprived populations in access, uptake and outcomes. This may lead to widening health inequalities, poorer health outcomes for vulnerable and inclusion groups, and increased demand on health and care services.					
Accountable:	Executive Director of Public Health				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Implementation of targeted plans to reduce inequity in uptake of vaccination, screening and diabetes prevention and care (1C.1) • Development and delivery of Regional Vaccine Equity Plan and Screening Equity Plan (1C.2–1C.3) • Partnership working with Primary Care to reduce variation in uptake (1C.4) • Development of jointly commissioned social prescribing services with Local Authorities and Third Sector (1C.5) • Implementation of Marmot / Anchor framework and system-wide prevention		G1: Limited system-wide adoption and prioritisation of Prevention / Anchor Wellbeing Framework across partners G2: Continued variation in access, uptake and outcomes between most and least deprived areas/groups G3: Insufficient targeting of interventions for inclusion health groups and vulnerable populations G4: Limited integration of population health intelligence to inform inequality reduction strategies G5: Requirement for whole system	Management Assurance IMTP monitoring of 1C deliverables (1C.1–1C.7) Performance monitoring: Vaccination uptake across deprivation quintiles Screening uptake and variation Diabetes care process delivery by cluster Programme governance (Public Health, Inequalities, Prevention programmes)	A1: Limited assurance of sustained reduction in health inequalities over time A2: Limited validation of impact of health inequality and prevention programmes A3: Data limitations affecting measurement of outcomes across deprivation and inclusion groups A4: Limited real-time evidence linking interventions to improved access and outcomes	

approaches (1C.6) • Development of inclusion health offer for vulnerable groups (1C.7) • Use of population health intelligence to target interventions in deprived and inclusion groups	approach to tackle health inequalities and wider determinants of health G6: Unable to implement at scale actions to address health inequalities	Risk & Compliance Assurance Alignment with: Wellbeing of Future Generations (Wales) Act Equality Act 2010 and Socio-economic Duty National Public Health and Equity strategies Internal reviews of equity plans and targeted programmes Independent Assurance Welsh Government oversight Regional Partnership Board reporting External benchmarking of inequality and equity measures	A5: Limited assurance of whole system approach to reducing health inequalities A6: Limited evidence of scale and spread of effective interventions which reduce health inequalities	

Plans to improve control :

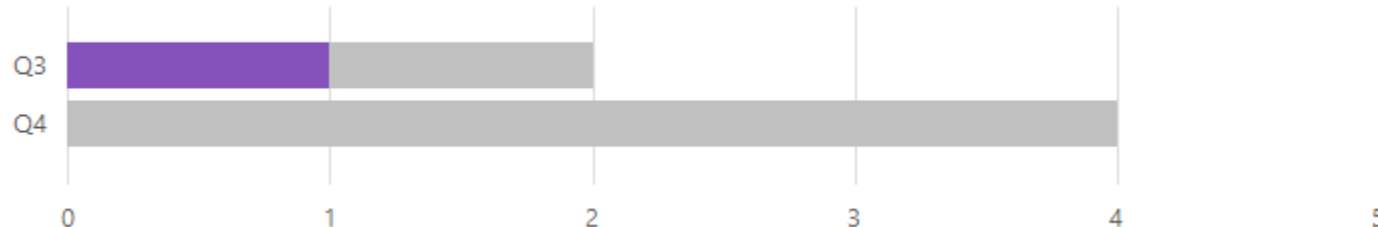
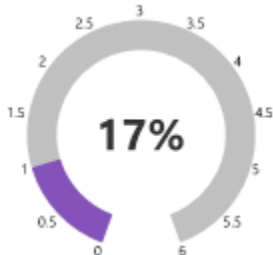


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1C.1	Implement plans which reduce inequity in the uptake in the most and least deprived areas in preventing ill-health, especially in relation to vaccination, screening and diabetes prevention and care. By utilising population health intelligence and evidence, target approaches to reduce variation and health inequalities within inclusion health groups and areas of deprivation.	G4	A1 A4 A6	Executive Director of Public Health	Q4 High Delivery Confidence

1C.2	Regional Vaccine Equity Plan co-developed and launched.	G2 G3 G4	A1 A3 A4 A5 A6	Executive Director of Public Health	Q2 High Delivery Confidence
1C.3	Regional Screening Equity Plan co-developed and launched.	G2 G3 G4	A3 A4 A5 A6	Executive Director of Public Health	Q4 High Delivery Confidence
1C.4	Work with primary care partners to reduce variation in vaccine uptake between primary care clusters.	G2 G3 G4 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	Q4 High Delivery Confidence
1C.5	Work with Local Authorities to secure jointly commissioned social prescribing services and expand creative offers with the Third Sector across North Wales.	G1 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	Q2 (Moderate Delivery Confidence)
1C.6	Supporting Marmot principles work towards a whole system shift to prevention and addressing inequalities by increasing the number of organisations/partnerships committing to, and evidencing early delivery against, the missions and Anchor Charter in the Regional Wellbeing, Prevention and Anchor Framework (missions: Environment, Communities, Housing, Food, Employment, Life-Long Learning, Active Lifestyles, Creative Lifestyles)	G1 G5	A5 A6	Executive Director of Public Health	Q4 High Delivery Confidence
1C.7	Based on the work in 2025/26 on the homelessness assessment, to comply with the new Homelessness and Social Housing Allocation (Wales) legislation and needs assessments on other inclusion groups, develop a comprehensive inclusion health offer for people in North Wales.	G2 G5	A1 A2 A3 A4 A5 A6	Executive Director of Public Health	Q3 High Delivery Confidence

Priority:	1D Health Protection			
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to protect the population from communicable disease and other health protection threats due to suboptimal vaccination uptake, increasing vaccine hesitancy, and ineffective management of environmental and societal risks. This may lead to increased spread of infectious disease, higher demand on services, and adverse population health outcomes.				
Accountable:	Executive Director of Public Health			
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
•Delivery of vaccination and immunisation programmes aligned to National Immunisation Framework (1D.1–1D.3) •Implementation of Vaccine Equity Plan and targeted uptake initiatives •Development of GP and IVS collaborative to improve uptake (1D.2) •Delivery of Health Protection Plan and establishment of Local Authority partnerships (1D.4) •Delivery of disease prevention, screening and elimination programmes (1D.5) •Infection prevention and control interventions across high-risk settings (1D.6) •Partnership working with Public Health Wales and Local Authorities	G1: Suboptimal vaccination uptake, particularly due to opt-out consent models G2: Increasing vaccine hesitancy driven by misinformation and lack of trust G3: Variation in vaccine uptake across communities and population groups G4: Limited targeting of high-risk and underserved populations G5: Requirement for Partner organisations to strengthen key aspects of health protection G6: Limited system-wide coordination of environmental and societal risk management	Management Assurance IMTP monitoring of 1D deliverables (1D.1–1D.6) Performance indicators: Childhood vaccination uptake HPV vaccination uptake Flu and RSV vaccination uptake Programme governance (Immunisation, Health Protection programmes) Risk & Compliance Assurance Alignment with: National Immunisation Framework Health Protection Framework (Wales) IPC standards and guidance Internal compliance reviews Independent Assurance Welsh Government oversight Public Health Wales monitoring of transmissible disease External benchmarking of vaccination uptake and disease control	A1: Limited assurance of achieving sustained herd immunity levels A2: Limited independent validation of vaccine uptake improvement interventions A3: Data limitations affecting targeting and monitoring of vaccination uptake A4: Limited real-time visibility of emerging health protection risks A5: Limited assurance of consistency in delivery across partners and communities A6: Limited evidence of long-term reduction in disease transmission and outbreaks	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
1D.1	Through targeted programmes of work for each vaccine / immunisation, implement the vaccine equity plan and work with partners (e.g. schools) to deliver the National Immunisation Framework targets to improve take up rates.	G1 G2 G3 G4	A1 A3 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1D.2	Develop the GP and Identified Validated Sample (IVS) collaborative to improve uptake in the RSV 75 plus cohort.	G2 G3 G4 G5	A1 A5	Executive Director of Public Health	Q4 High Delivery Confidence
1D.3	Implementation of phase 2 Childhood Immunisation Schedule recognising changes to the immunisation schedule for 2026, protecting children across a range of disease and illness.	G1 G2 G3	A1 A2 A3 A4 A5	Executive Director of Public Health	Q3 (Complete)
1D.4	Deliver the funded Health Protection plan including establishing a Health Protection partnership with a	G5 G6	A4 A5	Executive Director of Public Health	Q3 High Delivery Confidence

	Service Level Agreement in place with the 6 North Wales Local Authorities.				
1D.5	Enhance the delivery of health board services to protect people in North Wales against existing, new and emerging health protection threats and hazards by supporting screening and vaccination programmes, and disease elimination activities (Hepatitis B and C, and TB).	G4 G5 G6	A4 A6	Executive Director of Public Health	Q4 High Delivery Confidence
1D.6	Deliver evidence-based approaches to protecting and preventing ill health within specific sectors and settings e.g. delivery of infection prevention control interventions in residential Care Homes.	G5 G6	A1 A6	Executive Director of Public Health	Q4 High Delivery Confidence



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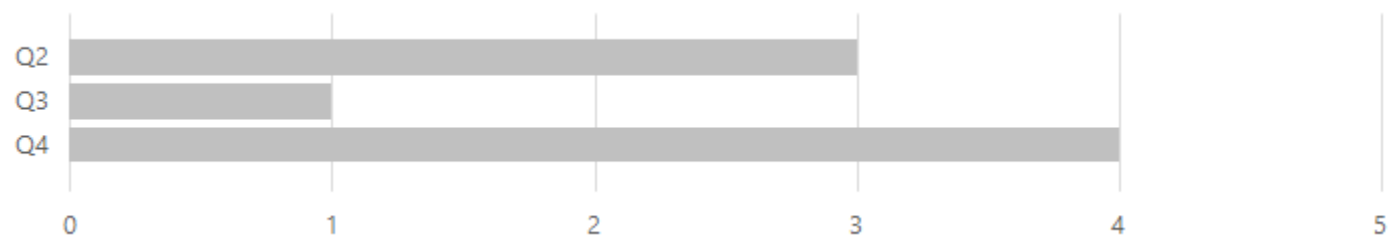
Enhance the coordination of care for people with long-term conditions and improve access to a broader range of community-based services by investing in integrated primary and community care and working collaboratively with partners.

Principal risk (What could prevent us achieving this strategic objective)	BAF 26 02 - Failure to deliver enhanced coordination of care for people with long term conditions & improve access There is a risk that the Health Board fails to improve coordination of care and access to integrated primary and community services for people with long-term conditions. This may lead to fragmented pathways, reduced community support, widening health inequalities, increased pressure on acute services, and poorer patient outcomes.		
Lead Committee	Partnership Finance and Information Governance Committee	Risk Type	Quality
Risk Lead	Chief Operating Officer	Risk Appetite	<15
Related Corporate Risks:	CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability		
Risk Rating		Review Dates	
	Current Exposure	Target	
Consequence	4	4	Initial assessment July 2026
Likelihood	4	3	Last Committee review
Risk Rating	16	12	Last Executive Review July 2026

Priority:	2A Primary Care
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver enhanced coordination of care for people with long-term conditions and improve access to primary and community-based services due to workforce challenges, service capacity constraints, contractual limitations, and the early maturity of transformation programmes. This may lead to reduced access to services, increased variation in care, poorer patient outcomes, and increased demand on acute services	
Accountable:	Chief Operating Officer

Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation and embedding of new GDS contract and dental service commissioning (2A.1–2A.2) Digital transformation of Community Dental Services (2A.3) Delivery of Primary Care Workforce Strategy (2A.4) Implementation of Community by Design programme (2A.5) Development of frailty model and proactive care approaches (2A.6–2A.7) Roll-out and promotion of NHS Wales App to improve access (2A.8) Performance monitoring of access, activity and outcomes	G1: Workforce capacity and sustainability challenges across primary care services G2: Variation in access to primary care services (e.g. dental, frailty care, chronic conditions) G3: Early maturity of Community by Design programme limiting delivery at scale G4: Limited contractual levers to drive change and improvement in primary care G5: Limited digital maturity and patient uptake of digital access solutions G6: Insufficient proactive management of long-term conditions within community settings	Management Assurance IMTP monitoring of 2A deliverables (2A.1–2A.8) Performance indicators: Dental access rates (P01–P02) Frailty management metrics (P03) Diabetes care processes (P05–P08) NHS App uptake (P09) Programme governance (Primary Care, Community by Design) Risk & Compliance Assurance Alignment with: National Primary Care Model for Wales Strategic Workforce Plan Contractual frameworks (GDS, GP services) Internal reviews and compliance monitoring Independent Assurance Welsh Government oversight External benchmarking of primary care access and outcomes Audit and regulatory review	A1: Limited assurance of sustained improvement in access to primary care services A2: Limited independent validation of impact of Community by Design programme A3: Limited data integration across primary and community care systems A4: Limited evidence linking primary care interventions to reduced acute demand A5: Limited assurance on reduction of variation across clusters and regions A6: Limited assurance on workforce sustainability and long-term capacity	

Plans to improve control :

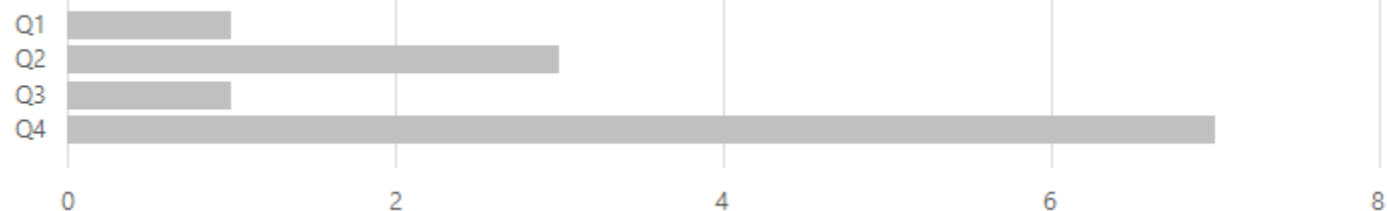


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2A.1	Ensure the new General Dental Service (GDS) contract is in place and embedded, with a clear plan for the procurement of new services including commissioning of tier 2 dental services where appropriate.	G2 G2 G4	A5	Chief Operating Officer	Q2 High Delivery Confidence
2A.2	Undertake a review of primary care dental services to assess current capacity, patient access, and service utilisation. Work with commissioned providers and system partners to identify opportunities to increase access for patients.	G2	A1	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
2A.3	Procure a robust digital system within the Community Dental Service (CDS) to support the management of patient records, and replace the current outdated system.	G5	A3	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
2A.4	Continue to deliver the Strategic Programme for Primary Care (SPPC) national 'Strategic Workforce Plan for Primary Care in Wales', with the aim of developing a sustainable, skilled workforce to meet the evolving healthcare needs of the population of North Wales over the next five years. Fully utilise the Work Based Learning Funding allocated to Primary Care to support delivery.	G1	A6	Chief Operating Officer	Q4 High Delivery Confidence
2A.5	The Health Board will strengthen the model of integrated primary and community care across	G3 G6	A3 A4	Chief Operating Officer	Q4

	North Wales by designing and delivering strategic priorities that align with the national Community by Design Transformation Programme. The key areas of focus will include urgent and same day care, management of chronic conditions in the community and prevention and population health management.				High Delivery Confidence
2A.6	Develop a costed primary care-led frailty model to enable proactive, coordinated care closer to home, as part of the Community By Design work. Identify the impact that current initiatives are having on maintaining patients at home.	G6	A4 A5	Chief Operating Officer	Q3 (No Update provided during this reporting cycle)
2A.7	Finalise a proposal to increase the use of the Audit Plus Frailty Tool in the community to ensure that patients receive proactive care in line with their agreed care plans.	G6	A4	Chief Operating Officer	Q4 High Delivery Confidence
2A.8	Support the implementation and roll-out of the NHS Wales app in primary and community care services by developing and implementing an action plan to promote the NHS app including patient education, staff training and monitoring of uptake.	G5	A1 A3	Chief Operating Officer	Q4 (Moderate Delivery Confidence)

Priority:	2B Community Care				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver coordinated, accessible, and high-quality community-based care for people with long-term conditions due to insufficient strategic planning, workforce and resource constraints, and lack of an agreed system-wide frailty and community care model. This may result in fragmented service delivery, increased variation in care, reduced access to services, increased demand on acute settings, and poorer patient outcomes					
Accountable:	Chief Operating Officer				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Development and delivery of Community by Design programme (2B.1) Demand and capacity review of community nursing services (2B.2) Mapping and redesign of Enhanced Community Care services (2B.3) Development of community investment fund with partners (2B.4) Strategic delivery plan for Palliative and End of Life Care (2B.5–2B.7) Review and optimisation of urgent community-based care services (2B.8) Delivery of coordinated care model for long-term conditions (2B.9) Implementation of frailty model and best practice standards (2B.10) Development of community diagnostic and breathlessness hubs (2B.11–2B.12)		G1: Lack of a fully agreed and embedded system-wide strategic plan for community care G2: Workforce and capacity constraints across community and primary care services G3: Early maturity of Community by Design programme limiting impact at scale G4: Variation in access and service provision across localities G5: Reliance on partner organisations and external providers G6: Limited integration and coordination of care for frailty and long-term conditions	Management Assurance IMTP monitoring of 2B deliverables (2B.1–2B.12) Performance metrics: Frailty pathway delivery Community nursing capacity Reduced hospital admissions and conveyance Programme governance (Community by Design, Frailty, Palliative Care) Risk & Compliance Assurance Alignment with: National Quality Statements (Frailty, End of Life Care) Community Care and Primary Care Models Internal service reviews and programme oversight Independent Assurance Welsh Government oversight External benchmarking of community services Regional partnership and system oversight	A1: Limited assurance of consistent delivery and access across all localities A2: Limited independent validation of Community by Design programme impact A3: Limited data integration and benchmarking of community services A4: Limited real-time evidence linking community interventions to reduced hospital demand A5: Limited assurance of consistent implementation of national standards A6: Limited evidence of sustainability of workforce and service models	

Plans to improve control :

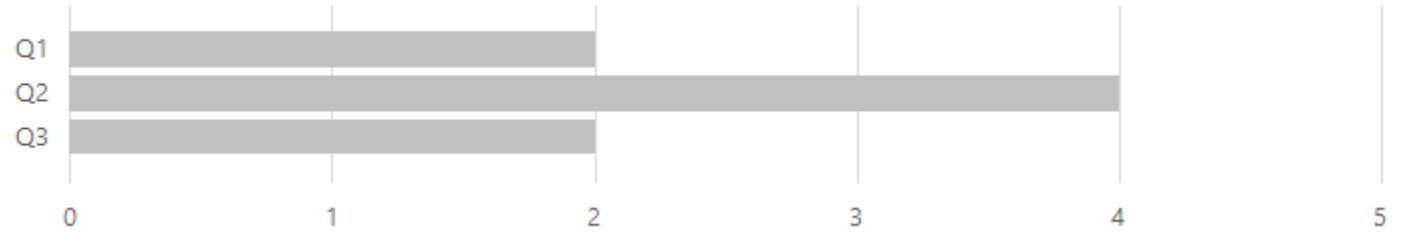


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2B.1	Develop Community by Design as a Major Change programme, working with partners to ensure it reflects national priorities and local needs.	G1 G3 G5	A2 A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
2B.2	Undertake a demand and capacity review to understand the levels of community nursing that are required across the Health Board, including weekend working.	G2 G4	A1 A6	Chief Operating Officer	Q2 (No Update provided during this reporting cycle)
2B.3	Map current Enhanced Community Care services across North Wales, identifying where services are located and the differences. Develop a proposal that offers recommendations as to how to further reduce unnecessary hospital conveyance and admissions.	G4 G6	A4 A5	Chief Operating Officer	Q4 (No Update provided during this reporting cycle)
2B.4	Develop a proposal for creating an investment fund for community groups and third sector organisations to work with the Health Board on community based solutions to some of the largest challenges facing the system.	G3 G5	A1 A5	Chief Operating Officer	Q1 (Low Delivery Confidence)
2B.5	Develop a strategic delivery plan for Palliative, End of Life and Bereavement Care (PEoLBC) in line with the All Wales Service Specification for the delivery	G1 G6	A1 A5	Chief Operating Officer	Q4

	of Palliative and End of Life care in Wales and All Wales Competency Framework. This will include consideration of how to increase weekend capacity for specialist palliative care nursing.				(Moderate Delivery Confidence)
2B.6	Agree an approved Quality Improvement Plan for End-of-Life Care Decision Making	G6	A1 A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
2B.7	Implement appropriate best practice within the national Quality Statement for Palliative and End of Life Care.	G6	A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
2B.8	Undertake a review of urgent care services available in the community including general practice, optometry, dental and pharmacy. Identify how services may be optimised and expanded.	G2 G4	A1 A4	Chief Operating Officer	Q2 (No Update provided during this reporting cycle)
2B.9	The Health Board will enhance the coordination of care for people with long term conditions and improve access to a broader range of community-based services, investing in integrated primary and community care.	G1 G3 G6	A2 A4 A6	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
2B.10	Implement appropriate best practice within the national Quality Statement for Older people and people living with frailty.	G6	A1 A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
2B.11	Develop a proposal to establish local breathlessness hubs to provide specialised support and care for people experiencing chronic breathlessness.	G2 G6	A1 A4	Chief Operating Officer	Q3 High Delivery Confidence
2B.12	Diagnostic Provision in the Community will be reviewed including undertaking a needs assessment for diagnostics and working with current providers to review and agree the most efficient delivery mechanism.			Chief Operating Officer	Q2 High Delivery Confidence

Priority:	2C Integrated Health & Well-being Hubs				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver Integrated Health & Well-being Hubs at pace and scale due to insufficient funding, workforce capacity constraints, and changing system priorities. This may result in delays to implementation, reduced access to integrated community-based services, missed opportunities to improve coordination of care, and continued pressure on acute services.					
Accountable:	Chief Operating Officer				
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating	
Delivery of Integrated Health & Well-being Hub programme across multiple sites (2C.1–2C.8) Strategic partnership working with Local Authorities, housing associations and third sector Development and approval of business cases and programme plans for hubs Governance through programme and capital planning frameworks Prioritisation through Integrated Rebalancing Capital Fund (IRCF) (2C.9) Alignment with Community by Design and wider strategic intent	G1: Funding constraints impacting pace and scale of hub development G2: Workforce capacity and contractor engagement challenges G3: Dependency on multi-agency partners and external decision-making G4: Risk of changing political or strategic priorities affecting delivery G5: Early stage of programme maturity across multiple sites G6: Limited capacity to scale integrated models consistently across North Wales	Management Assurance IMTP monitoring of 2C deliverables (2C.1–2C.9) Programme governance (Integrated Hubs Programme) Monitoring against programme milestones and timelines Risk & Compliance Assurance Alignment with: Health Board Strategy and Capital Programme National “A Healthier Wales” policy direction Internal programme and financial governance Independent Assurance Welsh Government oversight of capital and transformation programmes External scrutiny of business cases and funding approvals Partner organisation governance and reporting	A1: Limited assurance of delivery at pace across all hub developments A2: Limited independent validation of long-term impact of integrated hub model A3: Limited visibility of real-time progress across multiple programmes A4: Limited evidence linking hub delivery to improved outcomes and reduced demand A5: Limited assurance of consistent partner commitment across all sites A6: Limited assurance of sustainability of funding and workforce models		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
2C.1	Bangor Integrated Health & Well-being Centre – work with partners on a strategic outline case	G1 G3 G5	A1 A3	Chief Operating Officer	Q2 High Delivery Confidence
2C.2	Waunfawr Integrated Health & Well-being Centre – sign heads of terms to secure purchase of a site, progress the parallel elements of the programme plan.	G1 G3	A1 A3	Chief Operating Officer	Q1 (Moderate Delivery Confidence)
2C.3	Penygroes Integrated Health & Well-being Centre – develop an outline business case, progress the parallel elements of the programme plan.	G1 G5	A1 A3	Chief Operating Officer	Q3 (Moderate Delivery Confidence)
2C.4	Porthmadog Integrated Health & Well-being Centre – revise options appraisal for location, progress the parallel elements of the programme plan.	G1 G4	A1 A3	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
2C.5	Conwy West Integrated Health & Well-being Centre – finalise site location, progress the parallel elements of the programme plan.	G1 G5	A1 A3	Chief Operating Officer	Q2 (Low Delivery Confidence)
2C.6	Denbigh (Caledfryn) Integrated Health & Well-being Centre – finalise funding strategy, thereafter progress the programme plan.	G1 G2 G5	A1 A6	Chief Operating Officer	Q2 (Low Delivery Confidence)
2C.7	Holyhead Integrated Health & Well-being Centre – agree memorandum of understanding with Local Authority, thereafter progress the programme plan.	G3 G5	A5	Chief Operating Officer	Q1

					(Moderate Delivery Confidence)
2C.9	Finalise Integrated Rebalancing Capital Fund (IRCF) prioritisation.	G1 G4	A1 A3	Chief Operating Officer	Q3 (Low Delivery Confidence)



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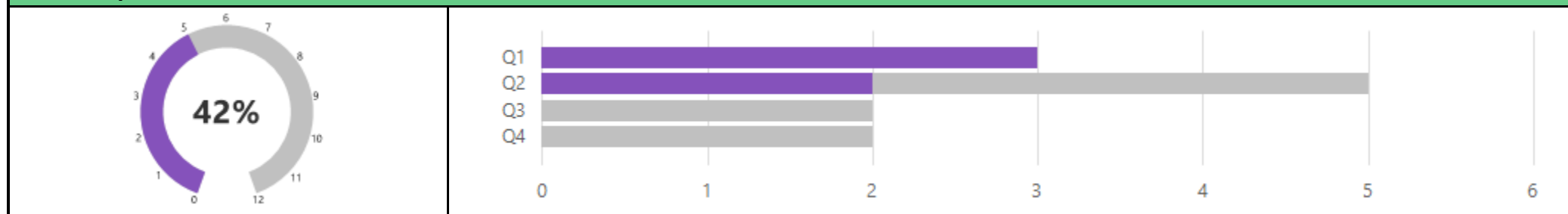
Improve access, outcomes and experience for all, developing and enhancing high-quality, high-value, and sustainable pathways of care for the region, delivered in partnership.

Principal risk (What could prevent us achieving this strategic objective)	BAF 26 03 - Failure to Improve access, outcomes & experience There is a risk that the organisation may be unable to deliver improved access, outcomes, and experience for all patients across the region if high-quality, high-value, and sustainable care pathways cannot be developed, enhanced, or delivered in effective partnership. This could result from constraints in workforce capacity, system pressures, service fragility, digital & infrastructure limitations, variation in pathway maturity, and insufficient collaboration with partners. Failure to mitigate this risk may lead to widening inequalities, reduced patient satisfaction, & an inability to meet regional population health needs			
Lead Committee	Performance Finance and Information Governance Committee, Quality, Safety Experience Committee, People & Culture Committee		Risk Type	Quality
Risk Lead	Chief Operating Officer		Risk Appetite	<15
Related Corporate Risks:	CRR25-01 – Timely Patient Access to Safe and Effective Care, CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan and Financial Sustainability, CRR08 – Partnership Working and System Integration			
Risk Rating			Review Dates	
	Current Exposure	Target		
Consequence	5	5	Initial assessment	July 2026
Likelihood	4	3	Last Committee review	
Risk Rating	20	15	Last Executive Review	July 2026

Priority:	3A Urgent and Emergency Care (UEC)			
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver sustained improvements in urgent and emergency care access, outcomes and patient experience due to constraints in recurrent funding, system capacity, workforce limitations and reliance on partner organisations, particularly during periods of increased demand				
Accountable:	Chief Operating Officer			
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
UEC Improvement Programme and IMTP deliverables (3A.1–3A.13) Programme governance including UEC Programme Board and NHS Wales oversight 90-day Operational Improvement Plans informed by 6As and GIRFT Daily–monthly operational escalation and performance monitoring Adoption of national best practice (triage, streaming, ambulance handover, senior decision making) Strengthened discharge pathways (D2RA and 7-day discharge model) Partnership working with WAST, Local Authorities and community services	G1: No confirmed recurrent funding for key UEC models (e.g. SDEC) G2: Insufficient 7-day and MDT capacity (SPOA, discharge, workforce) G3: Limited community capacity (CRT, falls response, D2RA resilience) G4: Dependence on non-recurrent funding and partner contribution G5: Variation in front-door processes, triage and workforce deployment G6: Inconsistent system-wide alignment and escalation during surge	Management Assurance Programme Board oversight of IMTP deliverables and system performance Ongoing operational reporting and improvement plan delivery Risk & Compliance Assurance Monitoring against national UEC standards (handover, 12-hour waits, etc.) Compliance with GIRFT and ED Quality Statement Internal audit review of governance and controls Independent Assurance NHS Wales Performance & Improvement oversight Welsh Government monitoring against trajectories	A1: Limited evidence on sustainability of improvements (particularly SDEC and surge) A2: Insufficient independent assurance on community capacity and CRT models A3: Weak triangulation of system-wide data (acute, WAST, partners) A4: Limited assurance on cross-organisational delivery (e.g. SPOA sustainability) A5: Insufficient independent validation of workforce and senior clinical cover A6: Limited evidence that 7-day and discharge models are consistently embedded	

		External validation (6As, GIRFT benchmarking)		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3A.1	Reduce avoidable ambulance conveyances and ED admissions from Care Homes through providing falls lifting equipment and level one falls prevention training to be delivered to 30 Care Homes across North Wales.	G3	A2	Chief Operating Officer	Q1 (Complete)
3A.2	Reduce avoidable ambulance conveyances and ED admissions from the community through producing an options appraisal for the National Six Goals Team to support funding for St John's Level 1 falls training and lifting equipment for Community Resource Teams (CRTs), ensuring a consistent pan North Wales approach to community-based falls response.	G3 G4	A2	Chief Operating Officer	Q2 (Complete)
3A.3	Reduce avoidable ambulance conveyances and ED admissions from the community by developing a proposal to use Six Goals Programme funding to increase Community Resource Teams (CRT)	G2 G3	A2	Chief Operating Officer	Q1 (Complete)

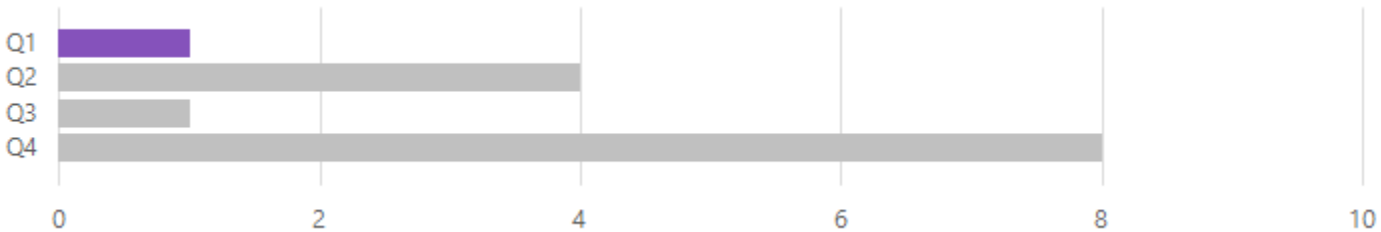
	capacity, focused on mobilising Band 3 therapy support staff as a dedicated pan BCU community falls response resource.				
3A.4	Reduce avoidable ambulance conveyances and ED admissions by transitioning from the current Single Integrated Clinical Assessment and Triage (SICAT) model to the Single Point of Access model (SPOA) with a broader Multi-Disciplinary Team (MDT) that is able to better sign post the most appropriate alternate to hospital treatment routes. This will ensure there is sufficient resource to operate the SPOA 7 days a week, 12 hours a day.	G2 G4 G6	A1 A4	Chief Operating Officer	Q4 (Low Delivery Confidence)
3A.5	Improve pathways of care delays out of the hospital through working more closely with the Local Authority Social Care Information Advice and Assistance (IAAs) team to improve referral pathways out of hospital.	G2 G4 G6	A3 A4	Chief Operating Officer	Q3 High Delivery Confidence
3A.6	Provide more suitable pathways for frail patients that ensure they have shorter lengths of stay within acute hospitals in line with the national Acute Frailty Service (AFS) model. Undertake baseline assessment and gap analysis for current Acute Front Door Frailty Services across all acute sites, identifying current service provision, workforce utilisation, SDEC alignment and opportunities to strengthen early frailty assessment and intervention.	G1 G6	A1 A3	Chief Operating Officer	Q1 (Complete)
3A.7	Adopt national best practice in relation to implementation of safe, fast, and consistent ambulance handover processes at the ED front door.	G5 G6	A1	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
3A.8	Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by standardising triage and streaming processes across all sites (majors, minors, SDEC, frailty).	G5 G6	A1 A2	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
3A.9	Reduce ambulance hours lost, improve hospital-wide flow and ambulance handover times by	G2 G5	A5	Chief Operating Officer	Q2

	strengthening senior clinical decision-maker presence at the front door, especially during periods of high demand.				(Moderate Delivery Confidence)
3A.10	Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, by strengthening application of community Discharge to Recover and Assess (D2RA) pathways, ensuring faster discharge options for frail patients.	G2 G3 G6	A1 A2	Chief Operating Officer	Q3 (Moderate Delivery Confidence)
3A.11	Reduce the number of people delayed in hospital and their length of stay, thereby reducing the potential for deconditioning, through implementation of Optimal Hospital Flow facilitators, utilisation of the Transport Coordination hub and enabling a 7-day discharge model across all acute sites.	G2 G3 G6	A1 A6	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
3A.13	Implement appropriate best practice within the national Quality Statement for Care in Emergency Departments.			Chief Operating Officer	Q2 (Complete)

Priority:	3B Planned Care, Cancer & Diagnostics				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely and sustainable improvements in planned care, cancer and diagnostics access, outcomes and patient experience due to challenges in achieving clinical consensus on service models, pace of pathway transformation (including PIFU/SOS), and workforce capacity and recruitment constraints					
Accountable:	Chief Operating Officer				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Planned Care Major Change Programme governance		G1: Variation in specialty engagement and readiness to adopt change	Management Assurance Programme Board and CSP governance oversight	A1: Limited assurance that consensus is achieved across all specialties	
Clinical Services Planning (CSP) Programme driving system-wide models		G2: Lack of standardised pathways and models across sites	Monitoring of IMTP deliverables (3B.1–3B.20)	A2: Insufficient independent validation of new service models	
Follow-up transformation workstream		G3: Workforce capacity constraints			

(PIFU/SOS – 3B.5, 3B.12) National guidance (GIRFT, CIN pathways, Cancer standards) Demand and capacity modelling supporting pathway design External support from Intensive Support Team (IST) Workforce redesign and fragile service improvement plans Investment in external capacity to protect performance	limiting delivery pace G4: Data quality and variation impacting decision-making G5: Inconsistent integration across primary, community and secondary care G6: Fragility of key services limiting ability to stabilise workforce and models	Specialty-level reporting on performance and transformation Risk & Compliance Assurance Monitoring against RTT, diagnostics and cancer standards Compliance with GIRFT, CIN pathways and national accreditation (e.g. JAG) Internal audit oversight of pathway and governance processes Independent Assurance Intensive Support Team (IST) and national programme oversight External clinical networks and benchmarking Welsh Government performance monitoring	A3: Weak triangulation of performance, quality and pathway data A4: Limited assurance that redesigned pathways are embedded consistently A5: Insufficient evidence that transformation will deliver improvement at pace A6: No full external assurance on long-term sustainability of workforce and models	

Plans to improve control :

 					
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action

3B.1	WS1 – RTT Pathway Validation: Consistent clerical and clinical validation will be in place incorporating national guidance and a suite of initiatives included expanding the reach of the EBO Virtual 'chat bot' for patient validation.	G3 G4	A3	Chief Operating Officer	Q4 (Low Delivery Confidence)
3B.2	WS2 – Referral Pathway Refinement: A range of initiatives to support a reduction in referrals to outpatients in high volume specialties, adopting best practice in waiting list management including the continuing roll out of the community health pathways, to ensure better prioritisation of available capacity for the longest waiting patients with a particular focus on unwarranted variation and associated referral threshold management.	G1 G2 G5	A1 A4	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
3B.3	WS3 – Booking Services: Reduce variation in outpatient waiting times and improve communication with patients on the waiting lists by adopting best practice including modernisation and standardisation of centralised booking services.	G2 G4	A4 A5	Chief Operating Officer	Q4 High Delivery Confidence
3B.4	WS4 – Pre-operative & Operative Effectiveness: Adopt best practice in theatre management through standardising pre-operative assessment process, and driving theatre productivity across North Wales. Undertake the national Surgical Hub Accreditation to support improved efficiencies and High Volume Low Complexity listings.	G2 G3	A2 A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
3B.5	WS5 – Follow-up Pathways: Modernise outpatient services management of follow-up care through ensuring consistent and best practice application of See on Symptom (SOS) and Patient Initiated Follow-up (PIFU) across all specialties and undertaking pathway validation and data quality cleanse of the follow-up waiting lists in line with the National Clinical Information Network (CIN) pathways and discharge protocols.	G1 G2 G3	A1 A3 A5	Chief Operating Officer	Q3 High Delivery Confidence
3B.6	Effective commissioning of planned care services in key specialties where core capacity and Waiting List	G3	A2 A5	Chief Operating Officer	Q4

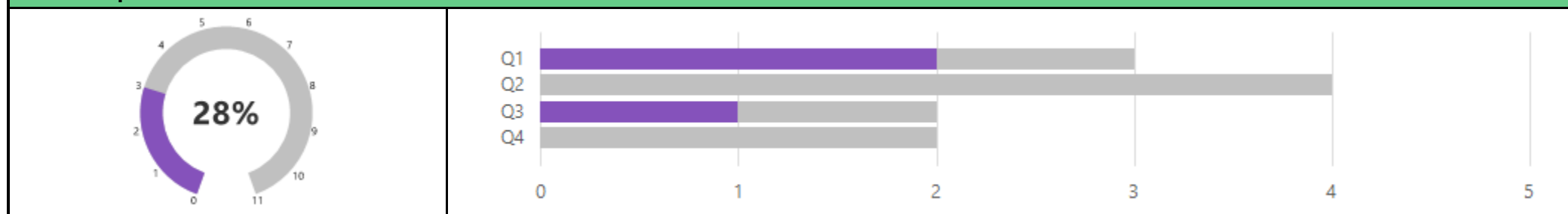
	Initiatives (WLLs) are insufficient to meet forecast demand.				(Moderate Delivery Confidence)
3B.7	Secure continuation of additional external capacity within dermatology, endoscopy, radiology and urology to meet existing demand into 2026/27. (Investment from Planned Care fund).	G3	A2 A5	Chief Operating Officer	Q1 (Complete)
3B.8	Agree the strategic model for the delivery of dermatology services in north Wales.	G2 G6	A2 A6	Chief Operating Officer	Q2 (Low Delivery Confidence)
3B.9	Agree the strategic model for the development of robotic assisted surgery in north Wales.	G2	A2 A6	Chief Operating Officer	Q2 High Delivery Confidence
3B.10	Finalise the oncology clinical strategic plan for north Wales.	G2 G5	A1 A2 A6	Chief Operating Officer	Q2 (No Update provided during this reporting cycle)
3B.11	WS6a – Cancer: Increase compliance with national optimal pathways with particular focus on increasing straight to test rates.	G4	A4	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
3B.12	Deliver opportunities for streamlined follow-up to improve patient care (e.g. Patient Initiated Follow-up – PIFU or See on Symptoms – SOS).	G1 G2 G3	A1 A6	Chief Operating Officer	Q4 High Delivery Confidence
3B.16	WS6b – Diagnostics: With the support of the NHS Wales Performance and Improvement (NHS Wales Performance & Improvement) develop diagnostics plans which are safe, sustainable and fit for the future. This includes the full implementation of digital technology as a key service enabler to address workforce shortages.	G4 G5	A2 A4	Chief Operating Officer	Q2 High Delivery Confidence
3B.17	Progress national business justification case for digital cellular pathology, enabling the service to fully realise clinical and operational benefits,	G4	A2 A6	Chief Operating Officer	Q4

	including overall increased reporting performance for routine cases in addition to those of higher clinical priority.				(Moderate Delivery Confidence)

Priority:	3C Fragile Services				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver safe, sustainable and equitable fragile services due to workforce constraints, financial limitations, challenges in agreeing service models, and operational pressures impacting delivery and resilience					
Accountable:	Chief Operating Officer				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Clinical Services Planning (CSP) Programme driving sustainable service models		G1: Ongoing workforce shortages and limited pipeline for key specialties	Management Assurance CSP Programme and Fragile Services governance oversight	A1: Limited assurance that workforce models will deliver long-term sustainability	
Fragile Services Programme governance and oversight		G2: Lack of sustainable workforce models and over-reliance on traditional roles		A2: Insufficient independent validation of redesigned service models	
Adoption of national guidance (GIRFT, Royal College standards, clinical networks)		G3: Financial constraints limiting service redesign and sustainability	Monitoring of IMTP deliverables (3C actions)	A3: Gaps in data quality and consistency across specialties	
Workforce planning, succession planning and skill mix redesign		G4: Fragmentation of services across sites limiting efficient use of capacity	Divisional reporting on workforce, performance and service delivery	A4: Limited evidence that service changes will improve resilience and outcomes	
Quality Management Systems (QMS) development across fragile services		G5: Limited capacity to deliver transformation due to operational pressures	Risk & Compliance Assurance Compliance with GIRFT recommendations and Royal College standards	A5: Insufficient assurance on reduction of reliance on locum/external capacity	
Networked service models across North Wales to share workforce and expertise		G6: Variation in pathway design, quality systems and data maturity	Monitoring of RTT, diagnostics and specialty-specific performance measures	A6: Limited visibility of long-term financial sustainability across fragile services	
Investment in external capacity where required			Development and implementation of Quality Management Systems		
Performance and quality oversight through IMTP delivery monitoring			Independent Assurance		

		External clinical networks and professional body reviews NHS Wales Performance & Improvement support and benchmarking Welsh Government oversight and reporting		

Plans to improve control :



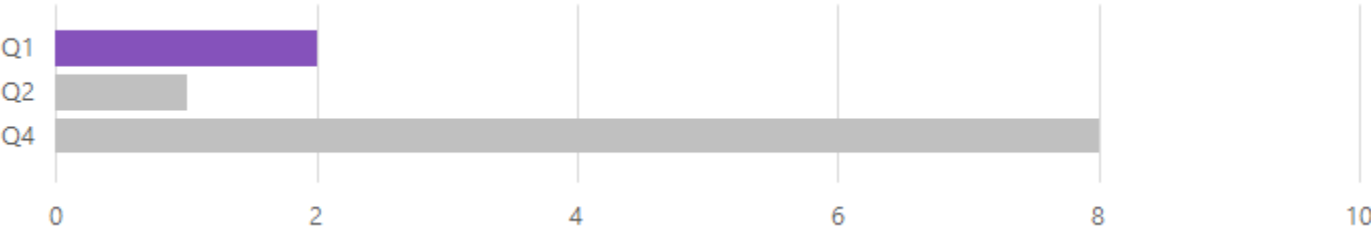
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3C.2	Commence implementation of vascular service review as part of the first tranche of Clinical Services Plan reviews, to:-Help strengthen integrated working across hub and spoke sites, -Support development of a skilled, happy and sustainable workforce,-Improve patient outcomes across key pathways-Ensure greater alignment with national guidance and best practice.	G2 G4 G6	A1 A2 A6	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
3C.7	Engagement and implementation of interim pan North Wales networked Dermatology service model, to better utilise resources (staff and funding) across North Wales. This is ahead of the full Clinical Services Plan work due to urgency around service sustainability especially in the West.	G4 G6	A2 A4	Chief Operating Officer	Q1 (No Update provided during this reporting cycle)

3C.8	Involvement in the full Clinical Services Plan work to design the long-term sustainable Dermatology model.	G4 G6	A2 A4	Chief Operating Officer	Q4 (No Update provided during this reporting cycle)
3C.9	Balancing Dermatology work between primary and community and secondary care – Further development of the Community Health Pathways and Teledermoscopy in order to reduce avoidable referrals into secondary care.	G2 G4 G6	A2 A4	Chief Operating Officer	Q2 (No Update provided during this reporting cycle)
3C.13	Full workforce review, succession planning, skills mix, expansion of roles such as Dentists with special interests, Orthodontic Therapists, to support more sustainable services.	G1 G2 G5	A1 A5	Chief Operating Officer	Q4 (No Update provided during this reporting cycle)
3C.14	Develop proposals to increase access to Cone Beam capable CT scanners, improving capacity and patient experience and travel.	G3 G6	A2 A4	Chief Operating Officer	Q3 (Complete)
3C.23	Full workforce review, succession planning, skills mix, expansion of roles such as Optometrists, Orthoptists, Advanced Clinical Practitioners, to support more sustainable services.	G1 G2 G5	A1 A5	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
3C.36	Further development of QMS to provide structured view and understanding of the drivers behind fragile services, through the triangulation of broad range of key data points.	G6	A3 A4	Chief Operating Officer	Q1 (Complete)
3C.37	Use the new QMS capability to map the highest priority services of concern as part of the Clinical Services Plan work, capturing the main KPIs for each that will be tracked to measure improvement.	G6	A3 A4	Chief Operating Officer	Q2 High Delivery Confidence
3C.38	Ensure that services of concern monitoring, escalation and de-escalation processes, governance and reporting are adequately covered within the	G6	A3 A4	Chief Operating Officer	Q3 (No Update provided)

	latest Performance and Accountability framework, covering both Executive and Board Member visibility. Including capturing how people's care and treatment outcomes are monitored and how they compare to similar services.				during this reporting cycle)
3C.39	Review and implement improvements to the governance surrounding services of concern, including establishment of both risks and separate issues logs.	G6		Chief Operating Officer	Q1 (Complete)

Priority:	3D Mental Health & Learning Disabilities				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, safe and high-quality mental health and learning disability services due to workforce capacity constraints, increasing demand and complexity, limitations in digital infrastructure, and challenges in implementing system-wide transformation and sustainable service models					
Accountable:	Executive Director of Allied Health Professionals and Health Science				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Mental Health Oversight and Development Group governance		G1: Workforce capacity constraints impacting delivery and transformation	Management Assurance Mental Health Oversight & Development Group monitoring delivery IMTP deliverables tracking (3D.1–3D.11) Performance monitoring against Mental Health Measure targets Programme reporting for EHR, crisis model and safety initiatives Risk & Compliance Assurance Compliance with national safety standards (72-hour follow-up, safe discharge)	A1: Limited assurance that transformation (e.g. Open Access model) will be delivered at pace	
National Patient Safety Programme implementation (Safe discharge, 72-hour follow-up)		G2: Lack of fully implemented and standardised service models (e.g. Open Access)		A2: Insufficient independent validation of new service models	
Crisis Care Model implementation		G3: Continued reliance on out-of-area placements due to capacity issues		A3: Gaps in digital and data visibility (pending EHR implementation)	
Development of Open Access Mental Health Service model		G4: Incomplete digital infrastructure (EHR not fully embedded)		A4: Limited triangulation of quality, safety and performance outcomes	
Engagement with national workstreams (MH strategy, physical health, LD frameworks)		G5: Variation across pathways and integration with partners		A5: Limited assurance that out-	
Electronic Healthcare Record (EHR) Transformation Programme		G6: Estate and infrastructure limitations affecting service delivery			

Performance monitoring through national Mental Health Measure standards Partnership working with Local Authorities and Regional Partnership Board		National MH & LD programme alignment and reporting Internal audits and governance reviews Monitoring out-of-area placements and patient safety incidents Independent Assurance Welsh Government oversight and reporting NHS Wales Performance & Improvement support External inspections/reviews (e.g. HIW, Royal Colleges where applicable)	of-area placements will be sustainably reduced A6: Insufficient evidence of long-term sustainability (workforce and estates)	

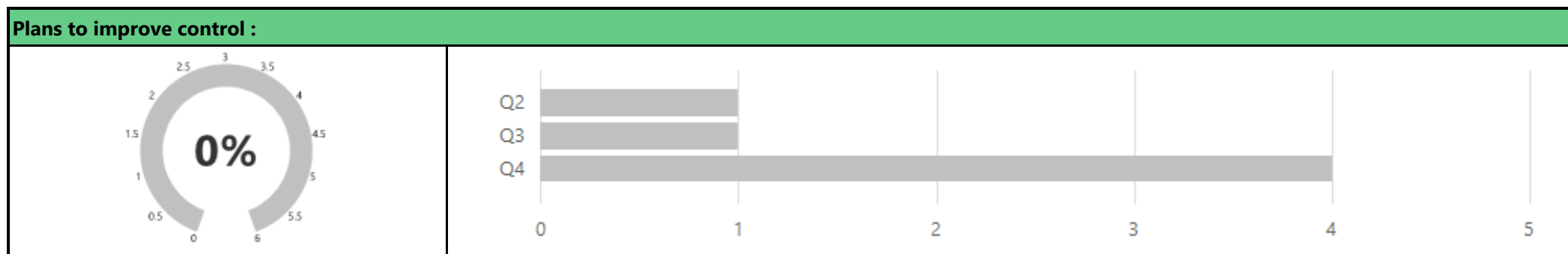
Plans to improve control :					
					
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3D.1	Engage with National Patient Safety Programme to improve quality and safety across services with the	G2 G5	A3 A4	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence

	implementation Safe Discharge and 72-hour follow-up standards.				
3D.2	Train inpatient staff on the use of ReQol 10 Patient Reported Outcome Measures (PROMS) alongside the National Programme Safety team.	G2	A3	Executive Director of Allied Health Professionals and Health Science	Q1 (Complete)
3D.3	Agree and develop with partners a phased Open Access Mental Health Service model with a view to implementing the demonstrator site by Q4 based on the international evidence base.	G1 G2 G5		Executive Director of Allied Health Professionals and Health Science	Q1 (Complete)
3D.4	Engage with the National workstream to Improve Physical Health of People with Severe and enduring Mental Illness including review and alignment of the BCU MHL D physical health policy in line with national developments.	G1 G2 G5	A1 A2 A5	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence
3D.5	Deliver a material reduction in the number of out of area placements through robust clinical and patient safety management (inclusive of community and acute staff) aligned to the implementation of the Crisis Care Model.	G2 G5	A2 A4	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence
3D.6	Reduce Health Inequalities for people with learning disabilities by increasing the uptake of the annual health checks and public health screening initiatives across services.	G1 G5	A4	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence
3D.7	Define and formally adopt a tiered crisis response framework for LD services with clear pathways for prevention, early intervention, urgent response, intermediate care provision in partnership with the Local authorities and post-crisis stabilisation.	G2 G5	A2 A4	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence
3D.8	Establish a digitally delivered specialist All-Wales gambling harm and treatment service.	G4	A2	Executive Director of Allied Health Professionals and Health Science	Q2 High Delivery Confidence
3D.9	Continue to progress the Electronic Healthcare Record (EHR) Transformation Programme which will reduce paper records and be a key enabler for service transformation, through commencing the implementation of the All Ages MHL D and	G4 G6	A3 A6	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence

	continued engagement with WG regarding a wider EHR.				
3D.10	Strengthen the strategic case for the development of the purpose-built, future-proof Adult and Older People Mental Health Unit at the Ysbyty Glan Clwyd site with the aim of presenting a full business case to Health Board for the approval by the end of Q4.	G3 G6	A2 A6	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence
3D.11	Progress the 13 key areas supported by the Board in the Scope of Mental Health Oversight and Development Group, including but not exhaustively; strategic plan and models of care, outcomes framework, performance, service user engagement, standards of clinical practice, workforce planning, estate and physical environment, culture and organisational development, leadership and management, legacy reviews, finance, dementia care and psychological therapies.	G1 G2 G6	A1 A6	Executive Director of Allied Health Professionals and Health Science	Q4 High Delivery Confidence

Priority:	3E Child and Adolescent Mental Health (CAMHs) & Neurodevelopment (ND)				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and effective CAMHS and neurodevelopment services due to increasing demand, workforce capacity constraints, long waiting times, and challenges in redesigning pathways towards a needs-led model and integrated system-wide approach					
Accountable:	Chief Operating Officer				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
CAMHS transformation aligned to national Mental Health Strategy		G1: Workforce capacity constraints limiting service delivery	Management Assurance CAMHS and ND programme governance	A1: Limited assurance that waiting times will reduce at required pace	
Neurodevelopment (ND) Improvement Programme		G2: Long waiting lists and backlog in neurodevelopment assessments	Monitoring of IMTP deliverables (3E.1–3E.6)	A2: Insufficient independent validation of pathway redesign effectiveness	
Partnership working through Children’s Regional Partnership Board		G3: Delays in access to CAMHS services and variation in pathways	Performance reporting against Mental Health Measure and ND waiting times	A3: Limited consistent data across ND pathways	
Early Help / Open Access model development		G4: Incomplete shift from diagnosis-led			

Crisis model redesign and implementation National guidance (NEST/NYTH framework, ND Code of Practice) Pathway standardisation and redesign across CAMHS and ND Performance monitoring (waiting times, Mental Health Measure)	to needs-led model G5: Fragmentation across health, education and social care partners G6: Limited capacity for early intervention and prevention	Regional partnership oversight (RPB) Risk & Compliance Assurance Alignment with national frameworks (NEST/NYTH, ND Programme) Monitoring of waiting times and access standards Internal governance and pathway compliance reviews Independent Assurance Welsh Government oversight NHS Wales Performance & Improvement support Regional Partnership Board scrutiny External programme reporting (ND Improvement Programme)	A4: Weak evidence of improved outcomes following transformation A5: Limited assurance of whole-system integration across partners A6: Insufficient evidence of long-term sustainability of workforce models	

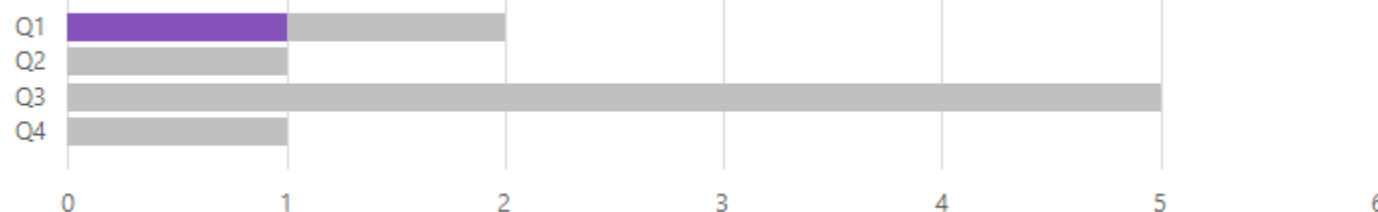
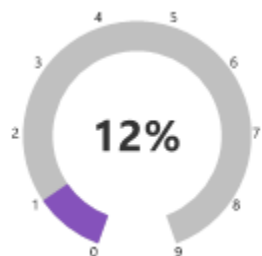


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3E.1	Early Help - Strengthen Early Intervention and Prevention. Develop and embed CAMHS Early Help systems and processes within the new model with partners across IHCs and regionally, to align with Flexible Open Access Mental Health Support and NYTH/NEST. Including: integration of schools in-reach, establishing reliable data reporting and measurement of impact, and establishing plans for secondary prevention that targets those at greatest risk of developing mental health problems.	G5 G6	A4 A5	Chief Operating Officer	Q4 High Delivery Confidence
3E.2	Improve access to CAMHS services by reducing and sustaining waiting times under the Mental Health Measure (MHM) and improving patient pathways to deliver better outcomes and experiences for Children and Young People (CYP). Including: exploring options for embedding Open Access principles, map and standardise pathways across the region using clinical guidelines and WG Community CAMHS service specification.	G1 G3	A1 A2	Chief Operating Officer	Q3 High Delivery Confidence
3E.3	Deliver a transformed and sustainable crisis model through full implementation and embedding of the crisis enhanced service model. Including working with adult mental health and partners on plans for an Open Access North Wales demonstrator project, develop and initiate plans for further Alternative to Admission, operationalisation of the 24/7 regional crisis consultation and advice line.	G1 G3 G5	A1 A2 A5	Chief Operating Officer	Q4 High Delivery Confidence
3E.4	Early Identification & Family Centred Support - Co-design new needs led model of care across children's neurodevelopmental (ND) services collaboratively with Children's Regional Partnership Board. Including: referral process review and improvement, roll out of standardised profile of need tool to be used prior to specialist ND referral	G4 G5	A4 A5	Chief Operating Officer	Q4 High Delivery Confidence

	is considered, ensure clear pathways and local points of access into ND services across all age groups, development of neuro affirmative communities.				
3E.5	Improved Access to Information, Guidance, and Assessment - Establish Clear, consistent access pathways in line with NEST/NYTH principles. Including streamline ND assessment prudent pathways to improve efficiency – introducing standard audit mechanisms and use of same day assessments for clear cases, enhance joint working across services and sectors - building links with education, CAMHS and third sector and piloting multi-agency ND input in schools.	G2 G3	A1 A3	Chief Operating Officer	Q2 High Delivery Confidence
3E.6	Improved post assessment/diagnostic support - Co-designed post-assessment support to ensure continuity, tailored interventions. Including: Map support offers regionally, align services to provide targeted post diagnostic support, ensure consistent signposting and referral pathways for support following diagnosis, develop ND transfer & transition protocols to provide seamless transition between child and adult services across agencies.	G3 G5	A4 A5	Chief Operating Officer	Q4 High Delivery Confidence

Priority:	3F Children and Young People Services			
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and high-quality services for children and young people due to health inequalities, workforce capacity challenges, gaps in community and specialist provision, and delays in implementing integrated pathways and preventative models of care				
Accountable:	Chief Operating Officer			
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Integrated Children’s Services model (community, hospital and specialist services) Partnership working with Regional Partnership Board and Local Authorities Delivery of national programmes (Healthy Child Wales Programme, immunisation programmes) Development of transition pathways from children to adult services Specialist service reviews (complex needs, palliative care, community nursing) Compliance with national guidance (NICE, WG frameworks) Performance monitoring (vaccination uptake, diabetes care, child health measures)	G1: Health inequalities affecting outcomes and access to services G2: Workforce capacity constraints across specialist paediatric services G3: Gaps in community nursing provision for children with complex needs G4: Delays in access to specialist care and interventions G5: Incomplete development of integrated pathways across organisations G6: Limited progress in prevention and early intervention models	Management Assurance Monitoring of IMTP deliverables (3F.1–3F.9) Performance reporting across child health indicators (immunisation, diabetes, etc.) Programme oversight for children’s services and partnership delivery Risk & Compliance Assurance Compliance with national frameworks (Healthy Child Wales, NICE guidance) Monitoring of access, waiting times and service provision Internal governance and service reviews Independent Assurance Welsh Government oversight Regional Partnership Board scrutiny External inspections/reviews where applicable (e.g. HIW)	A1: Limited assurance that inequalities will be reduced at pace A2: Insufficient independent validation of new service models A3: Limited data maturity across children’s services A4: Limited evidence of improved outcomes following interventions A5: Limited assurance of effective integration across partners A6: Insufficient clarity on long-term sustainability of service models	

Plans to improve control :



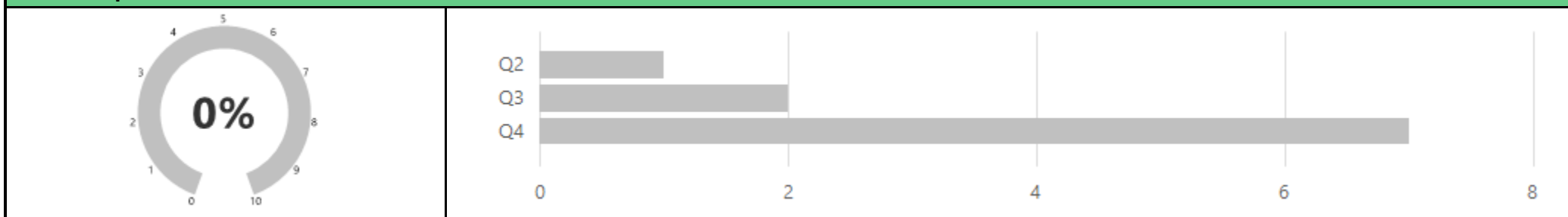
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3F.1	Delivery of school age immunisation programme by immunisation team with targeted work in low uptake areas.	G1 G6	A1 A6	Chief Operating Officer	Q4 High Delivery Confidence
3F.2	Working with partners, undertake a gap analysis of the requirements to fully implement the Healthy Child Wales 2 Programme and submit proposals to the Health Board for implementation.	G1 G5 G6	A1 A2 A5	Chief Operating Officer	Q3 (Moderate Delivery Confidence)
3F.3	Undertake a review of specialist nursing team roles and delivery of care for children with complex needs.	G2 G3 G4	A2 A4	Chief Operating Officer	Q1 High Delivery Confidence
3F.4	Commence developing a service specification for delivery of community nursing care for children with complex care needs	G3 G4 G5	A2 A4	Chief Operating Officer	Q3 High Delivery Confidence
3F.5	Ensure that children with diabetes have timely provision of insulin pumps and CGM	G2 G4	A4	Chief Operating Officer	Q2 High Delivery Confidence

3F.6	Assess compliance with Diabetes NICE Guidance in readiness for the launch of the Type 1 diabetes screening programme for children	G2 G4	A2 A4	Chief Operating Officer	Q3 High Delivery Confidence
3F.7	Set out the proposal to the Health Board based on the service specification gap analysis related to the submitted Paediatric Palliative Care in Wales self-assessment, including specialist palliative care nursing.	G3 G4 G6	A2 A6	Chief Operating Officer	Q3 (Moderate Delivery Confidence)
3F.8	Work with the Partnership Transformation Programme to commence the development of a strategic plan for children with a learning disability, and reduce inequalities for consultation.	G1 G5	A1 A5	Chief Operating Officer	Q1 (Complete)
3F.9	Finalise and implement the Transition Pathways for children into adult services across all long-term conditions (respiratory, endocrine, cardiac and neurological conditions, cancer, CAMHS and Learning Disabilities).	G4 G5 G6	A2 A4 A5	Chief Operating Officer	Q3 (Moderate Delivery Confidence)

Priority:	3G Women's Health				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver equitable, safe & high-quality women’s health services across the life course due to increasing demand, health inequalities, workforce & capacity constraints, & challenges in implementing national strategies, improving outcomes and reducing variation in access to services					
Accountable:	Chief Operating Officer				
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating	
Implementation of NHS Wales Women’s Health Plan (2025–2035) Delivery of Maternity and Neonatal Quality Statement (2025) Clinical Services Planning (CSP) for perinatal services	G1: Health inequalities impacting outcomes for women (especially deprived groups) G2: Workforce capacity and sustainability challenges in maternity and gynaecology G3: Variation in access and provision of	Management Assurance Monitoring of IMTP deliverables (3G.1–3G.10) Programme oversight for Women’s Health Plan delivery Maternity service performance reporting (incl. perinatal	A1: Limited assurance improvements will reduce inequalities at pace A2: Insufficient independent validation of new models of care (e.g. Women’s Health hubs)		

Digital Maternity Cymru System rollout (electronic maternity record) Partnership working with HEIW and third sector organisations Local delivery of women's health pathways (menstrual health, menopause, contraception etc.) Expansion of Women's Health Hub model (e.g. Llandudno) Participation in national digital/data programmes (Women's Health Dashboard)	key services (contraception, menopause, pelvic health) G4: Increasing complexity of care (e.g. diabetes, mental health in pregnancy) G5: Incomplete implementation of national strategies and frameworks G6: Limited maturity of digital and data systems across women's health pathways	outcomes) CSP programme oversight for perinatal services Risk & Compliance Assurance Compliance with national quality standards (Maternity & Neonatal Quality Statement) Monitoring against national indicators (perinatal mortality, patient experience) Internal governance, audits and service reviews Independent Assurance Welsh Government oversight and performance reporting HEIW workforce planning and assurance National programme boards (Women's Health, Maternity & Neonatal) External inspections/reviews (e.g. HIW)	A3: Limited national data and KPIs currently defined (dashboard still emerging) A4: Limited evidence linking interventions to improved outcomes A5: Limited assurance of consistency across regions and pathways A6: Uncertainty around long-term sustainability (workforce, funding, infrastructure)	

Plans to improve control :



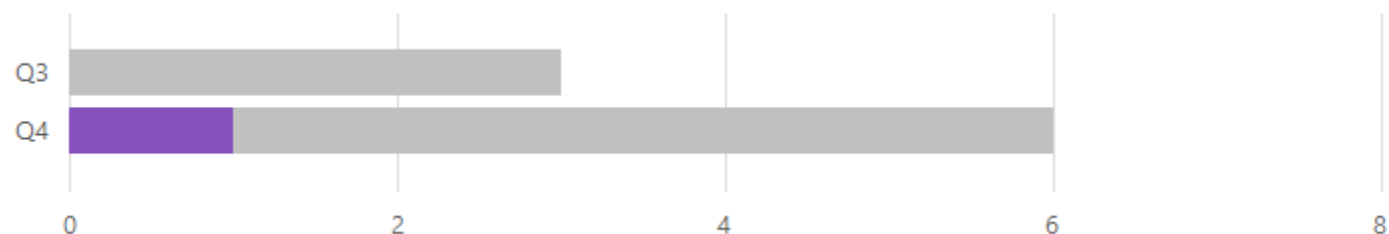
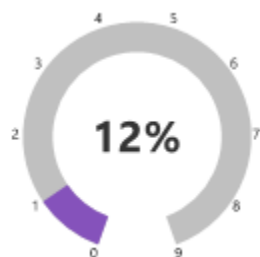
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3G.1	Progress the rollout of Phase 2 of the Digital Maternity Cymru System, with a focus on implementing maternity electronic health records to enhance the quality of care and improve communication for pregnant individuals.	G4 G6	A3 A4	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
3G.2	Receive and analyse the findings of the Perinatal National Assurance Assessment Report (expected in Q4 2025/26), together with the key priorities outlined in the 2025 Quality Statement for Maternity and Neonatal Services, and develop a comprehensive proposal for local implementation inclusive of detailed costing.	G2 G5	A2 A4	Chief Operating Officer	Q3 High Delivery Confidence
3G.3	As part of the Clinical Services Plan, undertake a comprehensive review of the configuration of Pan-North Wales Perinatal Services to ensure the delivery of safe, high-quality and sustainable care.	G2 G5 G6	A2 A5	Chief Operating Officer	Q4 High Delivery Confidence
3G.4	Develop an implementation plan to deliver the outstanding commitments in the National Perinatal Engagement Framework (2025), including a paid Chair for Maternity and Neonatal Voices Partnership.	G3 G5	A2 A5	Chief Operating Officer	Q2 (Moderate Delivery Confidence)
3G.5	Collaborate with Health Education and Improvement Wales (HEIW) to prioritise year two service actions to ensure the Perinatal Strategic Workforce Plan is delivered within the Health Board.	G2 G6	A6	Chief Operating Officer	Q4 High Delivery Confidence
3G.6	Support the local delivery of the NHS Wales Women's Health Plan across North Wales, to include work on Menstrual Health, Endometriosis and Adenomyosis, Contraception – Postnatal Contraception and Abortion Care, Preconception Health, Pelvic Health and Incontinence, Menopause, Violence Against Women – Domestic Abuse and	G1 G3 G6	A1 A4 A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)

	Sexual Violence, Ageing Well and Long-Term Conditions and strengthening community pathways.				
3G.7	Address variation in services such as Contraception, Menopause support and Pelvic Health.	G3 G5	A1 A5	Chief Operating Officer	Q4 High Delivery Confidence
3G.8	Deliver improvements to Women's Health prevention and early intervention, including preconception health and earlier identification of women's health conditions.	G1 G6	A1 A4	Chief Operating Officer	Q4 High Delivery Confidence
3G.9	Expand Women's Health service offering, currently focused via the Llandudno Womens Health Hub.	G3 G5	A2 A5	Chief Operating Officer	Q4 (Moderate Delivery Confidence)
3G.10	Participation in national digital and data development initiatives such as Women's Health Dashboard.	G6	A3 A4	Chief Operating Officer	Q3 (Moderate Delivery Confidence)

Priority:	3H Pharmacy and Medicines Management				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver safe, effective and sustainable pharmacy and medicines management services due to increasing demand, workforce capacity constraints, variation in prescribing practices, and challenges in implementing digital systems, optimising medicines use and supporting emerging therapies					
Accountable:	Executive Medical Director				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of High Value Medicines programme		G1: Workforce capacity and sustainability challenges	Management Assurance Monitoring of IMTP deliverables (3H.1–3H.9)	A1: Limited assurance that prescribing variation will reduce consistently	
Medicines optimisation through prescribing governance and NICE guidance		G2: Variation in prescribing practice across primary and secondary care	Performance reporting on prescribing metrics (e.g. PIPS uptake, prescribing rates)	A2: Insufficient independent validation of new service models (TrAMs, PIPS expansion)	
Development of Transforming Access to Medicines (TrAMs) programme		G3: Increasing demand and complexity of medicines use			

Expansion of Pharmacist Independent Prescribing Service (PIPS) Electronic Prescribing and Medicines Administration (ePMA) implementation Collaboration with HEIW and Bangor University to strengthen workforce pipeline Pharmaceutical Needs Assessment (PNA) and service planning Engagement with national genomics and advanced therapies programmes	G4: Incomplete digital maturity (ePMA / prescribing systems) G5: Limited capacity to support emerging therapies and innovation G6: Challenges in medicines optimisation and cost sustainability	Pharmacy programme governance (TrAMs, ePMA, Value & Sustainability Board) Risk & Compliance Assurance Compliance with NICE guidance and national prescribing standards Monitoring of high-value medicines and prescribing variation . Internal audit and medicines governance processes. Independent Assurance Welsh Government oversight National pharmacy and medicines optimisation programmes. All Wales Therapeutics and Toxicology Centre (AWTTC) reporting (where applicable). External regulatory oversight (e.g. GPhC for education and workforce).	A3: Limited maturity of prescribing data and digital analytics A4: Limited evidence linking medicines optimisation to improved outcomes A5: Limited assurance of future workforce sustainability A6: Uncertainty around delivery of advanced therapies and innovation capacity	

Plans to improve control :

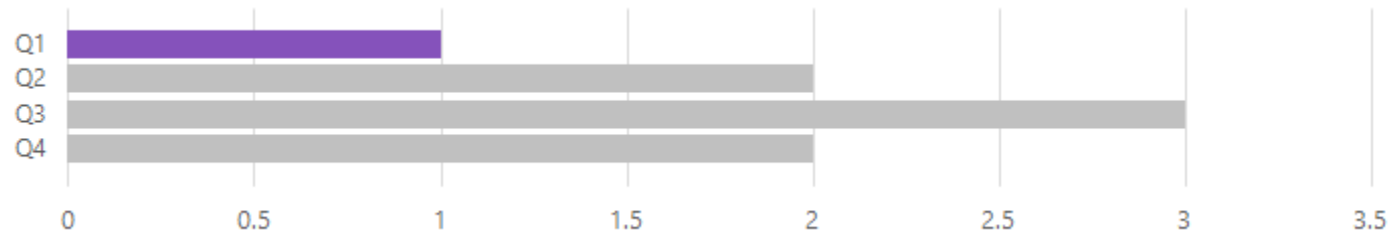
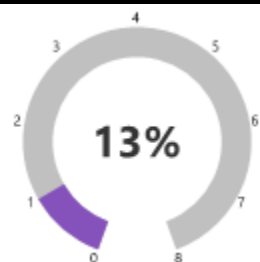


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3H.1	Commission and publish a Pharmaceutical Needs Assessment (PNA) and agree an action plan from this to ensure pharmaceutical services are aligned to population need, address gaps in provision, and support equitable, sustainable care delivery.	G1 G2 G6	A1 A5	Executive Medical Director	Q3 High Delivery Confidence
3H.2	Support General Pharmaceutical Council (GPhC) Step 4 accreditation for the Bangor University MPharm programme (confirming regulatory provisional accreditation to deliver the programme) and enrol Cohort 2 to strengthen the local pharmacy workforce pipeline and support sustainable service provision.	G1	A5	Executive Medical Director	Q3 High Delivery Confidence
3H.3	Launch and develop the North Wales Transforming Access to Medicines (TrAMs) programme, as one of three national transformation hubs, to modernise pharmacy technical services and strengthen regional collaboration, including scoping pharmacy provision to support advanced therapies within a national hub model.	G3 G5	A2 A6	Executive Medical Director	Q4 (Moderate Delivery Confidence)
3H.4	Continue to work with Community Pharmacy Wales (CPW) and Health Education and Improvement Wales (HEIW) to support community pharmacy contractors to expand the number of Pharmacies offering the Pharmacist Independent Prescribers Service (PIPS), strengthening prescribing capacity and improving access to care.	G1 G2	A1 A5	Executive Medical Director	Q4 (Moderate Delivery Confidence)
3H.5	Ensure full implementation of the High Value Medicines Value & Sustainability Board programme by supporting clinicians to adopt best-value prescribing practices, optimising procurement and product selection, reducing low-value prescribing, and strengthening performance oversight to deliver sustainable financial and quality benefits.	G4 G6	A1 A4	Executive Medical Director	Q4 (Complete)

3H.6	Following completion of implementation, fully embed Electronic Prescribing and Medicines Administration (ePMA) by establishing clear pharmacy clinical ownership to lead safe prescribing configuration, formulary oversight, system optimisation and structured change control.	G4 G6	A3 A4	Executive Medical Director	Q3 High Delivery Confidence
3H.7	Work with primary care and community services, via the Local Enhanced Clinical Effectiveness Service, to support evidence-based patient reviews that reduce inappropriate gabapentinoid prescribing in line with NICE guidance, extend periods of treatment, and increase the use of low Global Warming Potential inhalers in line with the All-Wales respiratory treatment pathway.	G1 G2 G3 G4 G6	A1 A4	Executive Medical Director	Q4 (Moderate Delivery Confidence)
3H.8	Engage with national genomics leads and clinical networks to scope the potential role of pharmacogenomics in clinical pathways, explore opportunities to develop local champions, and raise awareness through shared learning and engagement.	G5	A2 A6	Executive Medical Director	Q4 High Delivery Confidence
3H.9	Deliver the risk prioritised components of Electronic Prescribing Service (EPS) that sustain safe, reliable digital services, covering devices, network/telephony, core infrastructure, and clinical platforms.	G4	A3 A6	Executive Medical Director	Q4 (Low Delivery Confidence)

Priority:	3I Dementia				
Strategic Threat and Risks: There is a risk that the Health Board is unable to deliver timely, equitable and high-quality dementia services due to increasing demand, workforce capacity constraints, delays in diagnosis and access to services, variation in care pathways, and challenges in delivering integrated care across health, social care and third sector partner					
Accountable:	Executive Director of Nursing				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of the All-Wales Dementia Care Pathway of Standards		G1: Delays in diagnosis and access to memory assessment services	Management Assurance Monitoring of IMTP deliverables (3I.1–3I.8) Dementia programme governance and reporting. Performance monitoring (diagnostic rates, waiting times, service access). Risk & Compliance Assurance Alignment with All-Wales Dementia Standard.s Internal audits and service reviews. Monitoring compliance with national dementia pathways Independent Assurance Welsh Government oversight and performance reporting . Regional Partnership Board scrutiny. External inspections (e.g. HIW where applicable)	A1: Limited assurance that diagnostic waiting times will improve at pace	
Memory Assessment Services and diagnostic pathways		G2: Workforce capacity and capability gaps		A2: Limited independent validation of service redesign	
Community dementia services and multidisciplinary teams		G3: Variation in service provision and access across North Wales		A3: Data limitations impacting assurance reliability	
Partnership working with Local Authorities and third sector organisations		G4: Limited data quality and performance visibility		A4: Limited evidence of improved outcomes from interventions	
Dementia workforce training and development programmes		G5: Lack of fully integrated system-wide pathways		A5: Limited assurance of effective partnership integration	
Performance monitoring (diagnosis rates, waiting times)		G6: Challenges in hospital flow and discharge for dementia patients		A6: Limited assurance of workforce sustainability	
Carer support services and post-diagnostic support programmes					

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
3I.1	Complete a review of existing dementia care provision within Emergency Departments to include benchmarking against areas of best practice.	G1 G3	A1 A2 A4	Executive Director of Nursing	Q1 (Complete)
3I.2	Review analyse and make recommendations to the Health Board on the requirements to implement a Dementia Care Pathway for Emergency Departments.	G1 G3 G5	A1 A2 A5	Executive Director of Nursing	Q3 (Moderate Delivery Confidence)
3I.3	Design and deliver bespoke dementia patient and carer experience review for ED.	G1 G3	A2 A4	Executive Director of Nursing	Q3 High Delivery Confidence
3I.4	Undertake a review and training needs analysis of existing dementia training approaches and align national guidance and best practice standards, informing the development of a training programme for the workforce, building on the work completed for the bitesize training.	G2	A5 A6	Executive Director of Nursing	Q2 High Delivery Confidence
3I.5	Design and implement a programme tailored to the needs of the workforce to enable a consistent service delivery through agreement of a core minimum standard of dementia education across the Health Board.	G2 G5	A5 A6	Executive Director of Nursing	Q3 (Moderate Delivery Confidence)
3I.6	Undertake environmental assessments to review the Health Board's current assessment of appropriate	G3 G6	A2 A4	Executive Director of Nursing	Q2

	and suitable dementia friendly environments for all care settings and make proposals as appropriate.				(Moderate Delivery Confidence)
31.7	Recommendations and proposals collated and presented to the Health Board, working with Estates, to align any recommended improvements to Estates strategy and available budget.	G3 G6	A2 A6	Executive Director of Nursing	Q4 (Moderate Delivery Confidence)
31.8	Design and implement a staff campaign to raise awareness of prevention as it affects dementia.	G1 G5	A1 A4	Executive Director of Nursing	Q4 High Delivery Confidence



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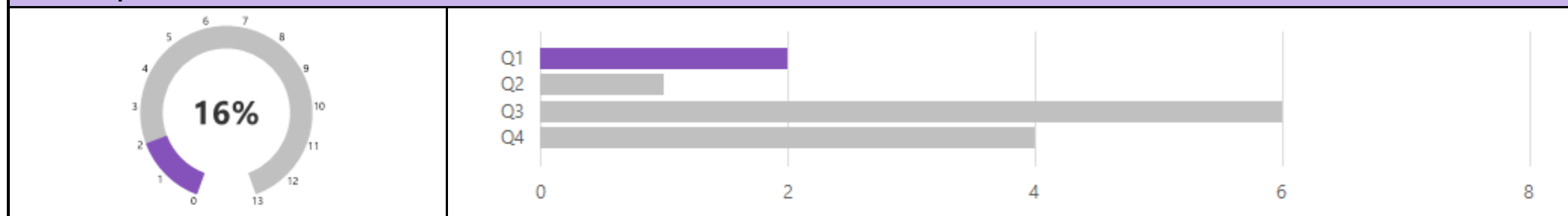
Create a modern, people-centred healthcare system that is future-focused, maximising opportunities of digital care, research, innovation, and improvement, investing in workforce development and wellbeing and strengthening our role as an anchor institution for North Wales.

Principal risk (What could prevent us achieving this strategic objective)	BAF 26 04 - Failure to deliver and create a modern, people centred heath care system that is future focused There is a risk that the Health Board is unable to deliver a modern, people-centred and future-focused healthcare system due to capacity constraints, workforce pressures, financial and infrastructure limitations, dependency on national programmes and funding, and the scale and complexity of transformation required across digital, estates, workforce, planning, quality &governance. Failure to modernise the system risks unwarranted variation in care, reduced workforce sustainability and resilience, loss of public confidence, increased scrutiny, and delayed Special Measures de-escalation.			
Lead Commitee	Planning, & Population Health and Partnerships Committee Performance, Finance & Information Governance Committee Quality, Safety & Experience Committee		Risk Type	Innovation
Risk Lead	Executive Director of People Services & OD, Executive Director of Nursing , Executive Director of Transformation and Strategic Planning, Executive Medical Director, Chief Digital & Information Officer, Director of Corporate Governance, Director of Partnerships, Executive Director of Finance and Director of Estates		Risk Appetite	<20
Related Corporate Risks:	CRR25-02 – Future Demand & Sustainable Workforce, CRR25-04 – Modernising Digital Infrastructure to Enable Safe, Integrated Care, CRR25-05 – Strategic Change Impacting Care and Staff Delivery, CRR25-06 – Delivery of the 2026/27 Financial Plan & Financial Sustainability, CRR25-07 – Leadership and Operating Model, CRR25-08 – Non-Compliance with Regulatory & Legislative Requirements, CRR25-09 – Safe Environment, CRR25-10 – Health & Safety, CRR25-11 – ICT Failure & Cyber			
Risk Rating			Review Dates	
	Current Exposure	Target		
Consequence	5	5	Initial assessment	July 2026
Likelihood	4	3	Last Committee review	
Risk Rating	20	15	Last Executive Review	

Priority:	4A Foundations for the Future				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to establish a coherent, effective and agile operating model due to challenges in organisational culture, workforce capability, governance, and process alignment. This may lead to inconsistent decision-making, lack of accountability, fragmented service delivery, and reduced organisational performance, impacting the delivery of high-quality, sustainable healthcare services.					
Accountable:	Executive Director of People				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of Culture, Leadership and Engagement programme (4A.1) Transition to new organisational structure and service groups (4A.2, 4A.7–4A.8) Development of leadership and competency frameworks (4A.3–4A.4) Improvement of governance, business case and ECR processes (4A.5–4A.6) Implementation of revised governance model and operating framework (4A.9–4A.11) Partner engagement to align operating model across system (4A.12) Development of organisational approach to change framework (4A.13)		G1: Risk of over-focus on structural change at expense of culture, people and processes G2: Workforce uncertainty and reduced morale during transition periods G3: Delays in implementation due to complexity of consultation and change processes G4: Limited maturity of governance and decision-making processes under new model G5: Limited organisational capability in delivering large-scale change consistently G6: Dependency on partner alignment and system-wide adoption of operating model	Management Assurance IMTP monitoring of 4A deliverables (4A.1–4A.13) Programme governance (Foundations for the Future Programme Board) Performance measures: Staff engagement index Evidence of team effectiveness and collaboration Risk & Compliance Assurance Governance reviews and internal audit of processes Alignment with: Workforce frameworks Governance and accountability frameworks Monitoring of implementation of new operating model	A1: Limited assurance of sustained impact of organisational change on outcomes A2: Limited independent validation of cultural and leadership improvements A3: Limited real-time insight into impact of transition on service delivery A4: Limited evidence linking operating model changes to improved performance A5: Limited assurance of consistency across divisions and services A6: Limited assurance of workforce stability and engagement during transition	

		Independent Assurance Welsh Government oversight (Special Measures framework) External audit and governance reviews Staff survey benchmarking		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4A.1	Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29. The delivery plan is structured into five areas. 1. Vision and Values, 2 Goals and Performance, 3. Learning and Innovation, 4. Support and Compassion, 5. Teamwork. Year one focusses on embedding systems and processes in these areas to improve leadership quality, employee engagement, psychological safety and practically embedding the agreed values and behaviours.	G1 G2 G5	A1 A2 A6	Chief Executive	Q4 High Delivery Confidence
4A.2	Complete the transition to new senior posts and establish new service groups and corporate directorates, supported by cross-functional	G2 G4	A3 A5	Chief Executive	Q4 High Delivery Confidence

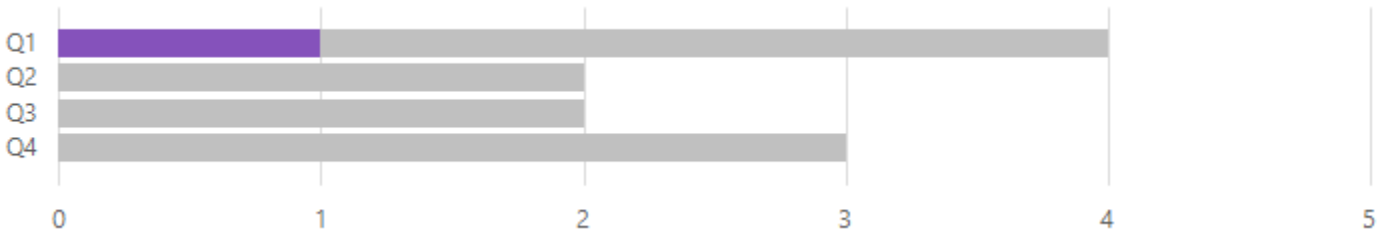
	operating agreements and ongoing team and leadership development.				
4A.3	Complete the revised Integrated Leadership Development Framework.	G5	A5	Chief Executive	Q1 (Complete)
4A.4	Complete Competency Frameworks, which includes the competencies and skills required for particular roles by banding, equipping staff with the skills to deliver their roles.	G2 G5	A6	Chief Executive	Q1 (Complete)
4A.5	Review and improve the Establishment Control Review (ECR) process, to ensure it is more streamlined and fully supported.	G4	A5	Chief Executive	Q3 (No Update provided during this reporting cycle)
4A.6	Review and improve the process for creating, reviewing, and approving business cases.	G4	A5	Chief Executive	Q3 High Delivery Confidence
4A.7	Implement the Foundations for the Future design and thereby establish a clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.	G1 G2 G4	A3 A5	Chief Executive	Q3 (Moderate Delivery Confidence)
4A.8	Complete the design of Phase 2. This will include reviewing the structures of the organisation at bands 8b and below, a plan for the effective integration of Mental Health and Learning Disabilities, and a rapid review of phase 1 implementation across all 5 pillars of the Programme.	G3 G5	A1 A4	Chief Executive	Q4 High Delivery Confidence
4A.9	Implement a new governance model as part of the revised operating model, ensuring sharper accountability, fewer/streamlined meetings, focusing on delivery and transparency.	G4	A4 A5	Chief Executive	Q2 High Delivery Confidence
4A.10	Publish to BCUIHB Board the collated lessons learned from Phase 1, including outcomes from the consultation process, evaluation of performance	G3 G5	A1 A4	Chief Executive	Q3 High Delivery Confidence

	and benefits measurement and how FFTF supports de-escalation by improving governance and accountability.				
4A.11	Publish the Operating Framework, including how business partnering will operate with the Service Groups, and the directory of services reflecting the new organisational model.	G4	A5	Chief Executive	Q3 High Delivery Confidence
4A.12	Engage with partners (JCC, NWAS, Local Government, Third Sector) to review the operating model and identify changes to the ways we operate and define operating policies and/or updated MOUs where applicable.	G6	A5	Chief Executive	Q4 High Delivery Confidence
4A.13	Co-produce with staff and partners an organisational approach to change framework that supports teams to successfully design, deliver and sustain change.	G5	A2 A6	Chief Executive	Q3 High Delivery Confidence

Priority:	4B Strategy and Planning				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to develop, align and deliver a robust long-term strategy and integrated planning framework due to operational pressures, limited stakeholder engagement, and external uncertainty. This may result in lack of strategic clarity, poor alignment between plans and resources, reduced organisational ownership, and inability to deliver sustainable transformation and improved outcomes.					
Accountable:	Executive Director of Transformation				
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating	
Delivery of 10-Year Strategy development (discovery, design and delivery phases) (4B.1–4B.3) Structured stakeholder engagement across organisation and partners Development of partnership frameworks (e.g. Third Sector collaboration) (4B.4)	G1: Long-term strategic direction not yet agreed, and therefore not yet fully embedded and understood across the organisation. G2: Inconsistent alignment between strategic priorities, operational plans and resource allocation. G3: Insufficient engagement and shared	Management Assurance - Board-approved 10-Year Strategy and associated strategic objectives. - Approved Integrated Medium Term Plan (IMTP) and annual planning cycle. - Integrated Planning Framework and planning guidance. - Strategy & Planning Programme	A1: Limited assurance that strategic priorities are consistently understood, owned and translated into operational delivery across all parts of the organisation. A2: Limited independent assurance regarding the effectiveness and impact of the Health Board's strategic		

Implementation of improved planning and modelling capability (4B.5, 4B.7–4B.9) Establishment of annual reflection and learning cycles (4B.6) Strengthened IMTP delivery monitoring and reporting (4B.11) Development of integrated planning and decommissioning approaches (4B.8, 4B.10)	ownership across clinical, operational and partner organisations G4: Integrated planning processes not fully mature or consistently applied across all services. G5: Limited organisational capability in strategic modelling, forecasting and scenario planning. G5: Variable ownership and accountability for delivery of strategic objectives. G6: Limited ability to systematically de-prioritise activity and redirect resources to agreed strategic priorities.	governance and reporting arrangements. - Quarterly performance reports demonstrating delivery against strategic priorities and IMTP commitments. - Executive performance reviews and accountability arrangements. - Strategic planning milestones and delivery monitoring. - Resource allocation and investment decision making processes aligned to strategic priorities Risk & Compliance Assurance - Assessment against NHS Wales Planning Framework requirements. - Planning Maturity Matrix self-assessment and improvement programme. - Internal reviews of planning, prioritisation and governance processes. - Compliance with Well-being of Future Generations duties and organisational planning requirements. - Monitoring of alignment between strategic, workforce, financial, digital and estate plans. Independent Assurance - Welsh Government review and oversight of Strategy and IMTP submissions. - Internal Audit reviews of planning, governance and	planning framework and decision-making processes.A3: Limited real-time visibility of alignment between strategy, plans, resources and delivery at organisational level A4: Limited evidence demonstrating a clear link between strategic objectives, investment decisions and improved organisational or population outcomes. A5: Limited assurance regarding the consistency and maturity of planning practices across services, directorates and programmes. A6: Limited assurance that resource allocation, prioritisation and de-prioritisation decisions are systematically aligned to strategic priorities and long-term sustainability.	

		strategic decision-making processes. - Audit Wales reviews relating to planning, governance and organisational resilience. - NHS Performance & Improvement reviews - External benchmarking of planning maturity and organisational performance. - Stakeholder and partner feedback regarding strategic engagement and alignment.		

Plans to improve control :					
					
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4B.1	Complete the Discovery Phase of the new 10-year Health Board Strategy by finalising evidence gathering, synthesising insights from key stakeholders, and undertaking structured engagement across the organisation and wider partners. This will culminate in an agreed Discovery Report, to inform the subsequent Design Phase of the Strategy. This work will also cover some specific requirements within the NHS Wales Planning Guidance:• A review of the organisation's Well-	G1 G2 G4	A1 A3	Executive Director of Transformation & Strategic Planning	Q1 (Low Delivery Confidence)

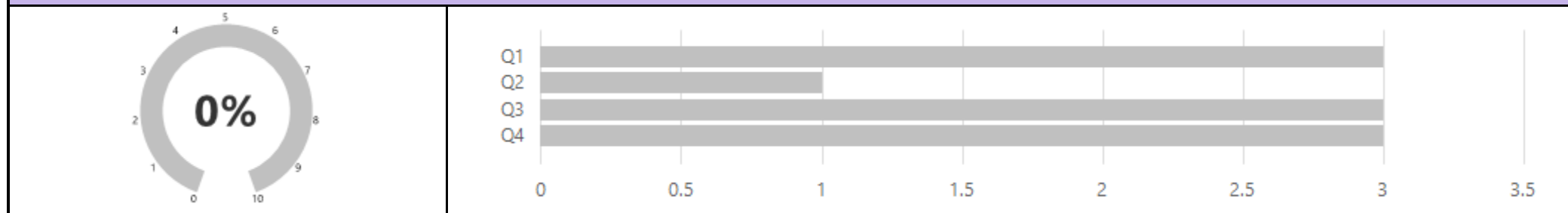
	being objectives and how they fit within the Health Board's overarching strategic objectives. Provide clarity on the full suite of underpinning strategic plans (such as the Clinical Services Plan, Estates Strategic Plan and Digital Strategic Plan) and timelines for their development. Incorporate the Health Board's ambitions relating to Advanced Therapies and Genomics.				
4B.2	Complete the full strategy design phase by translating the insights from the discovery phase into a validated strategic framework, including defined goals, strategic priorities, delivery roadmaps, and governance model, culminating in a final Strategy ready for Board approval. This will include structured engagement with key stakeholders throughout the design process to test assumptions, refine options, and build organisational alignment, ensuring aspects such as the Marmot principles (relating to early childhood, education, employment, preventing ill-health, housing and community well-being) are covered within the scope.	G1 G6	A1 A4	Executive Director of Transformation & Strategic Planning	Q3 (Moderate Delivery Confidence)
4B.3	Implementation of the strategy will be via key underpinning quality impact assessed strategic plans (e.g. Clinical Services Plan) and their key deliverables falling within the 2027-30 IMTP.	G4 G6	A4 A6	Executive Director of Transformation & Strategic Planning	Q4 (Moderate Delivery Confidence)
4B.4	Co-create a Third Sector Partnership Working Framework with Third Sector Partners to move to more proactive and strategic collaborative approach.	G1 G3	A1 A5	Executive Director of Transformation & Strategic Planning	Q1 (Moderate Delivery Confidence)
4B.5	Draw on support from NHS Performance and Improvement (NHS P&I) colleagues to develop proposals on an improved approach to a unified modelling across demand, capacity, skills mix, activity, performance, finance and workforce, incorporating benchmarking against other Health	G5	A3 A6	Executive Director of Transformation & Strategic Planning	Q1 (Low Delivery Confidence)

	Boards – to be utilised in the 2027-30 IMTP planning cycle.				
4B.6	Undertake an annual reflection and learning exercise in relation to the annual planning cycle, incorporating the planning maturity matrix self-assessment tool and involving internal and external stakeholders.	G4 G5	A2 A5	Executive Director of Transformation & Strategic Planning	Q1 (Complete)
4B.7	Deliver improvements in the organisation's approach to planning through delivery of the planning capability action plan that is informed by feedback from key stakeholders, annual learning cycles and contains actions from the planning maturity matrix self-assessment. Aiming to progress to level 3 and above across all areas.	G4 G5	A5	Executive Director of Transformation & Strategic Planning	Q4 High Delivery Confidence
4B.8	Update the BCUHB Integrated Planning Framework and associated more detailed planning guidance in light of annual reflection and learning exercise, emphasising the importance of clinical leadership, Community by Design principles and patient feedback in service planning.	G4 G6	A3 A5	Executive Director of Transformation & Strategic Planning	Q2 High Delivery Confidence
4B.9	Contribute to the broader organisational capability development work, specifically in relation to development of skills in planning.	G5	A6	Executive Director of Transformation & Strategic Planning	Q2 High Delivery Confidence
4B.10	Develop an organisational approach to de-prioritisation and de-commissioning for teams to utilise in reaching and implementing decisions of this nature, ensuring the full range of clinical and operational perspectives are central to the approach.	G6	A4 A6	Executive Director of Transformation & Strategic Planning	Q3 High Delivery Confidence
4B.11	Support delivery of commitments set out in the IMTP through monthly monitoring and timely escalation of any risks to delivery as well as quarterly reporting of delivery against the IMTP and Special Measures de-escalation framework.	G2 G4	A3 A4	Executive Director of Transformation & Strategic Planning	Q4 High Delivery Confidence

Priority:	4C Clinical Services Planning, Leadership and Interprofessional Working			
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively develop and deliver the Clinical Services Plan (CSP), alongside strong clinical leadership and interprofessional working, due to organisational change, insufficient resources, external uncertainty, and limited clinical engagement in leadership roles. This may result in delayed or ineffective service transformation, lack of clinical ownership, inconsistent leadership capacity, and an inability to deliver sustainable, high-quality, person-centred care aligned to strategic objectives and population needs.				
Accountable:	Executive Medical Director / Executive Director of Transformation			
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Establishment of CSP Programme governance, delivery plans and reporting structures (4C.1–4C.2) • Delivery of CSP assessment process including evidence gathering, population health intelligence and option appraisal (4C.3) • Development and approval of CSP service change proposals (4C.4) • Implementation of clinical leadership roles, job descriptions and remuneration models (4C.5) • Delivery of clinical leadership training and development programmes (4C.6–4C.7) • Development of clinical leadership career pathways (4C.8) • Strengthening interprofessional working through clear roles, responsibilities and OD support (4C.9–4C.10)	G1: CSP programme at early stage of development and not fully embedded across all services G2: Variable engagement across clinical, operational and partner stakeholders G3: Limited clinical leadership pipeline and capacity across services G4: Insufficient prioritisation of resources (time and funding) to support CSP delivery G5: Dependencies on operating model changes affecting programme coordination and engagement G6: Interprofessional working arrangements not consistently embedded across teams	Management Assurance • IMTP monitoring of 4C deliverables (4C.1–4C.10) • CSP Programme governance and reporting arrangements • Evidence of completed CSP assessments and approved service change proposals • Workforce metrics including clinical leadership vacancies and training uptake • Staff engagement and organisational development feedback Risk & Compliance Assurance • Alignment with Clinical Services Plan requirements, IMTP and 10-year strategy • Internal governance and performance reporting frameworks • Oversight of workforce and leadership development programmes Independent Assurance • Welsh Government oversight of IMTP delivery and service	A1: Limited assurance of consistent engagement and ownership across all services and partners A2: Limited independent validation of CSP effectiveness and decision-making outcomes A3: Limited real-time visibility of CSP delivery progress and alignment with strategy A4: Limited evidence linking CSP delivery to improved population and service outcomes A5: Limited assurance of leadership capacity and capability development impact A6: Limited assurance of sustainability of delivery within available resources	

		transformation • External benchmarking and learning from other Health Boards • Stakeholder and partner feedback on CSP engagement and proposals		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4C.1	Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.	G1 G2 G5	A1 A3	Executive Medical Director	Q1 (Low Delivery Confidence)
4C.2	Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments. Success will be	G1 G4	A3	Executive Medical Director	Q2 (Moderate Delivery Confidence)

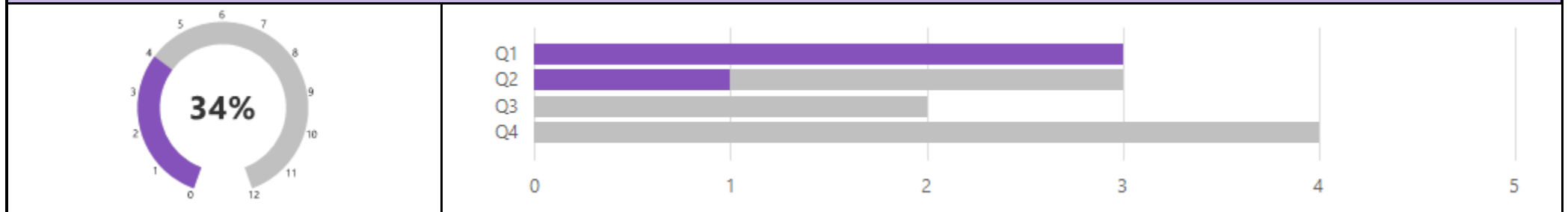
	demonstrated through approved delivery plans, active reporting cycles, and evidence of areas' readiness to enter the CSP process in Q3.				
4C.3	Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.	G1 G2	A3 A4	Executive Medical Director	Q3 (Moderate Delivery Confidence)
4C.4	Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.	G1 G6	A4	Executive Medical Director	Q4 (Moderate Delivery Confidence)
4C.5	Job descriptions with roles with responsibilities and appropriate remuneration in place for all clinical leadership posts with Foundations for the Future organisation structure, across primary, community and secondary care.	G3	A5	Executive Medical Director	Q1 (Low Delivery Confidence)
4C.6	Commence implementation of a menu of formal training programmes informed by training and	G3	A5	Executive Medical Director	Q3

	development needs analysis for all within clinical leadership positions, across primary, community and secondary care.				(Low Delivery Confidence)
4C.7	Generalised upskilling related to modern NHS needs via Clinical Services Plan programme to include strategic planning, value-based health care, population health management etc, across primary, community and secondary care.	G3	A5	Executive Medical Director	Q4 (Low Delivery Confidence)
4C.8	Develop a clear and attractive career path and development package for those in or aspiring to Clinical Leadership position, drawing on internal and external expertise and support including NHS P&I and CMO. Across primary, community and secondary care.	G3	A5	Executive Medical Director	Q4 (Low Delivery Confidence)
4C.9	Provide clarity over best practice clinical and operational multi-professional working, in line with the new operating model structures roll out, both roles and responsibilities and effective team working. Across primary, community and secondary care.	G6	A1	Executive Medical Director	Q1 (Low Delivery Confidence)
4C.10	Provide organisation development support to ensure newly formed teams are working effectively together across clinical and operational inter-professional disciplines. Across primary, community and secondary care.	G2 G6	A1	Executive Medical Director	Q3 (Low Delivery Confidence)

Priority:	4D Digital, Data and Intelligence			
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a robust, integrated digital, data and intelligence capability due to insufficient funding prioritisation, dependencies on internal and external partners, and limited clinical and operational capacity. This may result in delayed digital transformation, poor data quality and intelligence, reduced ability to support decision-making, and an inability to deliver safe, efficient and modern technology-enabled healthcare				
Accountable:	Chief Digital & Information Officer			
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Development and implementation of demand and capacity planning tools (4D.1) • Rollout of data quality kite mark and data governance programme (4D.2–4D.4) • Development of data governance audits and frameworks to improve data accuracy and accountability (4D.3–4D.4) • Implementation of clinical coding quality dashboards and improvement initiatives (4D.6–4D.8) • Development of population health intelligence and analytics capabilities (4D.11–4D.12) • Implementation of digital skills assessment and training programmes (4D.13–4D.14) • Programme of decommissioning legacy systems and reducing technical debt (4D.15) • Development of AI governance framework and digital roadmap aligned to CSP and strategy (4D.18–4D.19) • Strengthening cyber security and compliance through Cyber Assessment Framework gap analysis (4D.17)	G1: Funding not consistently prioritised across digital and data initiatives G2: Dependencies on national programmes, partners and internal transformation limiting delivery G3: Limited clinical and operational capacity to support digital transformation G4: Variable data quality and governance maturity across organisation G5: Digital and analytical capability not fully embedded across services G6: Legacy systems and infrastructure impacting efficiency and integration	Management Assurance • IMTP monitoring of 4D deliverables (4D.1–4D.20) • Digital programme governance and reporting arrangements • Data quality kite mark assessments and data governance audits • Clinical coding performance dashboards and reporting • Digital skills training uptake and workforce development metrics Risk & Compliance Assurance • Compliance with Cyber Assessment Framework (CAF) requirements • Information governance and data quality frameworks • Oversight of digital clinical safety and cyber risks at Board level (4D.20) Independent Assurance • Welsh Government oversight of digital transformation and IMTP delivery • External benchmarking and national digital programmes • Audit and review of data	A1: Limited assurance that digital investment decisions are prioritised and deliver expected benefits A2: Limited visibility and control over dependencies impacting delivery timelines A3: Limited assurance of clinical engagement and capacity to support digital implementation A4: Limited confidence in consistency and quality of data across organisation A5: Limited evidence of impact of digital transformation on service outcomes A6: Limited assurance over full integration and sustainability of digital systems	

		governance, cyber security and system performance		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4D.1	Identify and commence implementation of best practice and tools available to support improved organisation wide demand and capacity planning.	G3 G5	A3 A5	Director of Digital, Data & Intelligence	Q2 (Moderate Delivery Confidence)
4D.2	Further development and roll out throughout the year of the data quality kite mark to provide assurance on data quality and accuracy.	G4	A4	Director of Digital, Data & Intelligence	Q4 (Moderate Delivery Confidence)
4D.3	Develop and commence implementation a programme of data governance audits to provide assurance on data processing and reporting accuracy.	G4	A4	Director of Digital, Data & Intelligence	Q1 (Complete)
4D.4	Develop a data quality framework that makes clear the responsibilities and accountability associated with the collection and management of data across the health board.	G4 G5	A4	Director of Digital, Data & Intelligence	Q3 High Delivery Confidence
4D.6	Develop and implement a Clinical Coding quality dashboard to facilitate improved clinical coding error detection and correction.	G4	A4	Director of Digital, Data & Intelligence	Q1 (Complete)

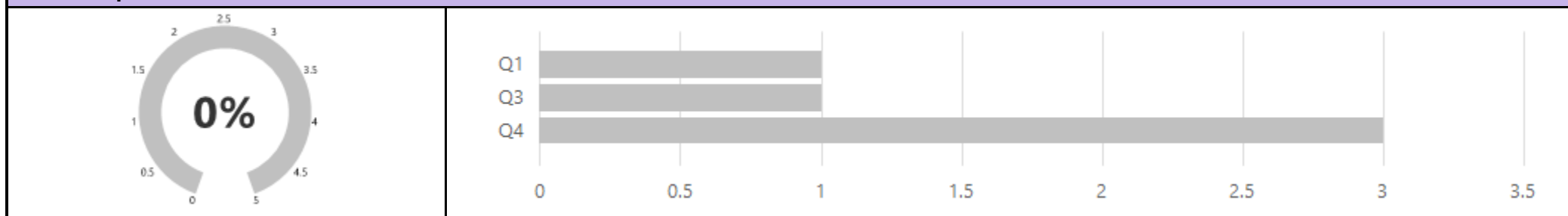
4D.11	Further enhance existing information products to introduce elements of Population Health Management (PHM) e.g. deprivation analysis, further identification of patient cohorts for targeted interventions.(Shared objectives with Public Health Team on PHM).	G5	A5	Director of Digital, Data & Intelligence	Q3 High Delivery Confidence
4D.13	Implement a comprehensive Digital Skills Assessment and publish Training Needs Analysis and Academy plan on LMS landing page.	G3 G5	A3	Director of Digital, Data & Intelligence	Q1 (Complete)
4D.15	Progressively and systematically decommission and archive unsupported systems and devices in line with available resources, while maximising the efficient use of current supported systems to reduce technical debt, support costs, and safety risk.	G6	A6	Director of Digital, Data & Intelligence	Q4 (Moderate Delivery Confidence)
4D.17	Completion of a gap analysis against the requirements of the newly released Cyber Assessment Framework (CAF) version 4 – this will be the tool used by our regulators to measure compliance.	G2	A2	Director of Digital, Data & Intelligence	Q2 (Complete)
4D.18	Create and establish a robust AI framework to ensure the appropriate processes, people and governance arrangements are in place. This will provide assurance that the approval/review process in place provides structure for the appropriate and safe use of AI tools which considers all 7 AI principles, covering safety, confidentiality, research, evaluation, partnership, ethics, transparency, and data quality.	G2 G5	A2 A6	Director of Digital, Data & Intelligence	Q2 (No Update provided during this reporting cycle)
4D.19	To review the organisational wide Digital Roadmap to take into account the 10 year strategy and Clinical Service Plan.	G1 G2	A1 A2	Director of Digital, Data & Intelligence	Q4 (No Update provided during this reporting cycle)

4D.20	Ensure that digital clinical safety, cyber security and information governance risks in relation to digital are considered by the board, and undertake regular board development sessions to develop digital and data competence.	G2 G3	A2 A3 A6	Director of Digital, Data & Intelligence	Q4 (No Update provided during this reporting cycle)

Priority:	4E Research, Development and Innovation				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively grow and sustain research, development and innovation (RD&I) activity due to limited pipeline of studies, insufficient capacity to support research delivery, and challenges in securing external funding. This may result in reduced research activity, missed opportunities for innovation, limited access to funding and partnerships, and an inability to improve patient outcomes, workforce development and organisational learning.					
Accountable:	Executive Medical Director				
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating	
Approval and delivery of RD&I strategic plan aligned to Health Board priorities and national expectations (4E.1) Development of proposals for an innovation centre in partnership with industry and academia (4E.2) Embedding research expectations into clinical roles, job plans and appraisals (4E.3) Increasing research study activity and recruitment through improved processes and engagement (4E.4) Strengthening academic partnerships and joint appointments to support research and innovation (4E.5)	G1: Limited pipeline of research studies and opportunities G2: Insufficient capacity (PI, workforce and support services) to deliver research activity G3: Limited capability and capacity for bid writing and securing external funding G4: Research and innovation not fully embedded as core part of clinical practice G5: Dependency on external partners and funding environment G6: Limited coordination and visibility of RD&I activity across the organisation	Management Assurance • External review through research networks and academic partners • Benchmarking against national research activity and funding metrics • Oversight and requirements from Welsh Government and Health and Care Research Wales Risk & Compliance Assurance • Alignment with Health and Care Research Wales and national policy requirements • Governance oversight of research activity and compliance processes • Monitoring of research performance metrics (recruitment to target, study delivery timelines)	A1: Limited assurance on sustainability and growth of research pipeline A2: Limited visibility of capacity constraints impacting research delivery A3: Limited assurance over success rates for funding and bid quality A4: Limited evidence of impact of RD&I activity on patient outcomes and service improvement A5: Limited assurance that research is consistently embedded into clinical practice and workforce roles		

		Independent Assurance • IMTP monitoring of 4E deliverables (4E.1–4E.5) • RD&I programme governance and reporting • Metrics on number of studies opened and recruitment levels • Monitoring of research funding applications and awards		

Plans to improve control :

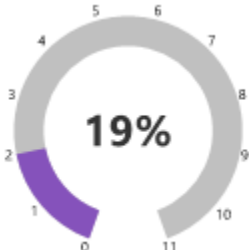
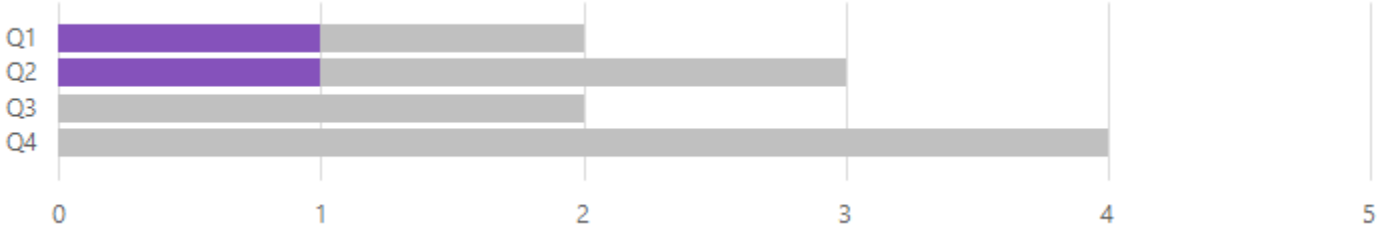


Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4E.1	RD&I strategic plan and delivery plan approved, aligned to health board strategic intentions and national performance metric.	G4 G6	A1 A5	Executive Medical Director	Q1 (Moderate Delivery Confidence)
4E.2	Develop a proposal for a self-sustaining innovation centre, working with industry and academia, prioritising digital innovations and medical technology, aligned with the NHS Wales Technical Planning Guidance 2026-29 Digital and Innovation enabling plan, and Welsh Government's Innovation Strategy delivery plan.	G3 G5	A3 A4	Executive Medical Director	Q3 High Delivery Confidence
4E.3	Work with People Services colleagues to develop and implement a plan to normalise research as a core part of clinical practice by embedding research	G2 G4	A2 A5	Executive Medical Director	Q4 High Delivery Confidence

	expectations within job descriptions, appraisal objectives, and job plans for identified priority staff groups, supported by guidance and manager training.				
4E.4	Increase the number of non-commercial and commercial research studies opened by the Health Board and recruitment to those studies, through proactive engagement with sponsors and streamlined feasibility and approval processes.	G1 G2	A1 A2	Executive Medical Director	Q4 (Moderate Delivery Confidence)
4E.5	Work with local academic partners to identify and implement to increase joint appointments and/or honorary contracts, closely working with the Academic Careers Community of Interest, ensuring that posts add value to research and innovation activity and support the above actions.	G2 G5	A2 A5	Executive Medical Director	Q4 High Delivery Confidence

Priority:	4F Education Partnership and Projects, Academic Careers and Strategic Alignment of Education				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to effectively develop and deliver its education partnerships, academic career pathways and strategic alignment of education due to dependency on national programmes, limited operational capacity for placements, and challenges in aligning education with service transformation. This may result in reduced workforce pipeline, limited development of academic careers, and failure to align education provision to future service and workforce needs.					
Accountable:	Executive Director of People Services & OD				
Primary risk controls:	Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating	
Engagement with Further and Higher Education partners to align education provision with Clinical Services Plan (4F.1) • Development and monitoring of Memoranda of Understanding (MoUs) and partnership delivery plans (4F.2, 4F.5) • Exploration of opportunities through regional partnerships including the Tertiary Alliance (4F.3) • Development of Academic Careers pathways	G1: Dependencies on national programmes and timelines impacting local delivery G2: Limited operational capacity to support student placements across services G3: Academic career pathways not fully embedded or developed G4: Inconsistent alignment between education provision and	Management Assurance • IMTP monitoring of 4F deliverables (4F.1–4F.11) • Education Steering Group and governance reporting • Monitoring of MoU delivery plans and partnership activity • Workforce and education metrics (placements, recruitment pipelines)	A1: Limited assurance of alignment between education provision and future service needs A2: Limited visibility of placement capacity and impact on workforce pipeline A3: Limited evidence of effectiveness of academic career pathways		

and Community of Practice (4F.7–4F.8) • Establishment of governance structures for education aligned to workforce and service needs (4F.9) • Development of Strategic Education Plan aligned to HEIW and national priorities (4F.10) • Compliance with national legislative and education requirements (4F.11)	service/workforce needs G5: Limited coordination and oversight of partnerships and education delivery G6: Variable engagement across services in supporting education and training	Risk & Compliance Assurance • Alignment with HEIW strategies and national education frameworks • Compliance with statutory requirements (e.g. Additional Learning Needs Act) • Oversight of education governance and workforce planning alignment Independent Assurance • External partner feedback from universities and FE providers • National oversight through HEIW and Welsh Government • Evaluation of partnership effectiveness and student pipeline outcomes	A4: Limited assurance over consistency and quality of partnership delivery A5: Limited assurance of sustainability of education models within operational constraints	

Plans to improve control :					
					
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4F.1	Work with Further and Higher Education Partners to capture their contribution to the development of the Health Board's clinical services plan so that	G4 G6	A1 A4	Executive Director of People Services & Organisational Development	Q1 (Moderate Delivery Confidence)

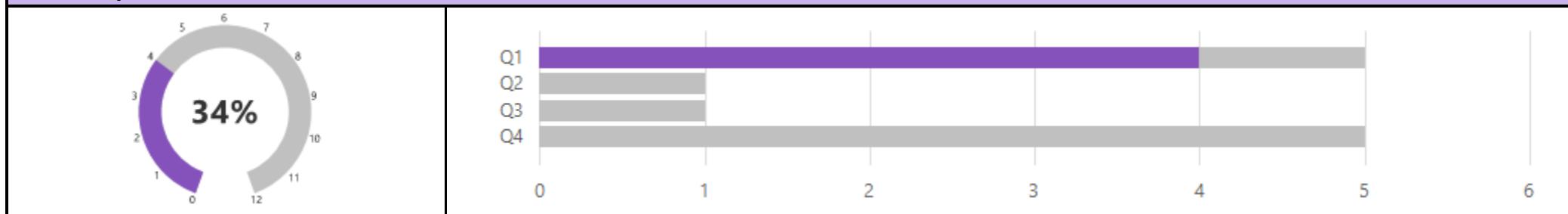
	education provision across the region can reflect the future development of healthcare.				
4F.2	Review and set out proposals to the Health Board on requirements to meet Memoranda of Understanding with Further and Higher Education Partners and reflect in delivery plans aligned to national programmes and strategies, with agreed key metrics and baselines.	G5	A4	Executive Director of People Services & Organisational Development	Q3 High Delivery Confidence
4F.3	Review opportunities for BCUHB to support the Tertiary Alliance formed between Bangor University, Wrexham University, Grwp Llandrillo Menai and Coleg Cambria.	G1 G5	A4	Executive Director of People Services & Organisational Development	Q3 High Delivery Confidence
4F.4	Continue to support the development of the proposed Dental School and input into associated business cases.	G2 G6	A2	Executive Director of People Services & Organisational Development	Q4 High Delivery Confidence
4F.5	Submit an evaluation of progress against the aspirations set out in the Memoranda of Understanding with Further and Higher Education Partners, providing recommendations on how performance against key metrics may be enhanced.	G5	A4	Executive Director of People Services & Organisational Development	Q4 High Delivery Confidence
4F.6	Commence full business case for the North Wales Medical school in partnership with Bangor University.	G2 G5	A2 A4	Executive Director of People Services & Organisational Development	Q1 (Complete)
4F.7	Conduct an analysis as to the key barriers in establishing academic careers and update the pathway framework accordingly.	G3	A3	Executive Director of People Services & Organisational Development	Q2 (Complete)
4F.8	Having established an Academic Careers Community of Practice to bring together academics across BCUHB, develop a delivery plan which will outline how we should enhance their work and maximise its impact within BCUHB.	G3 G6	A3	Executive Director of People Services & Organisational Development	Q2 High Delivery Confidence
4F.9	Develop a proposal for an interprofessional governance structure setting out clear governance routes and alignment of education to strategic workforce planning and the quality, safety and experience of our services.	G4 G5	A1 A4	Executive Director of People Services & Organisational Development	Q2 (Moderate Delivery Confidence)

4F.10	Progress to the Design Phase for education and training, agreeing priorities together with the development of an underpinning Strategic Education Plan which aligns to HEIW and local commissioning of education and training.	G4	A1	Executive Director of People Services & Organisational Development	Q4 (Moderate Delivery Confidence)
4F.11	Collaboration with education colleagues to comply with the duties set out in the Additional Learning Needs and Education Tribunal (Wales) Act.	G2	A2	Executive Director of People Services & Organisational Development	Q4 High Delivery Confidence

Priority:	4G Value & Sustainability				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a sustainable Value & Sustainability programme due to insufficient identification and delivery of recurrent savings, disruption from organisational change, and competing operational pressures. This may result in increased financial deficits, reduced ability to invest in transformation, failure to shift resources to higher-value care, and an inability to deliver efficient, high-quality and sustainable services.					
Accountable:	Executive Director of Finance				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Development of Value & Sustainability programme aligned to national priorities and Board objectives (4G.1–4G.12) • Implementation of clinical variation programmes to reduce unwarranted variation and improve efficiency (4G.1–4G.4) • Development of non-pay and procurement programmes to optimise resource use (4G.5) • Implementation of medicines management programme aligned to national priorities (4G.6) • Development of continuing healthcare (CHC) programme to manage demand and cost pressures (4G.7) • Implementation of value-based healthcare approaches to improve outcomes and resource use (4G.8–4G.11) • Delivery of agreed savings targets through refreshed Value & Sustainability programme (4G.12)		G1: Insufficient pipeline of savings opportunities to meet recurrent targets G2: Disruption from operating model changes impacting programme delivery G3: Operational pressures limiting focus on transformation and prevention G4: Inconsistent identification and delivery of value opportunities across services G5: Limited embedding of value-based healthcare principles in decision-making G6: Limited capacity and capability to deliver efficiency and productivity improvements	Management Assurance • IMTP monitoring of 4G deliverables (4G.1–4G.12) • Value & Sustainability Programme governance and reporting • Monitoring of savings delivery against agreed targets • Performance and productivity metrics Risk & Compliance Assurance • Alignment with national Value & Sustainability Board priorities • Financial governance and reporting frameworks • Oversight of programme delivery through Finance and Performance governance	A1: Limited assurance of delivery of recurrent savings at required scale A2: Limited visibility of impact of operating model changes on savings delivery A3: Limited assurance that transformation and prevention programmes are being prioritised A4: Limited evidence linking value initiatives to improved outcomes and efficiency A5: Limited assurance of consistent application of value-based decision-making across organisation	

		Independent Assurance • Welsh Government oversight of financial performance and IMTP delivery • External benchmarking of productivity and efficiency • Audit review of savings programmes and financial controls		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4G.1	Review current progress with the implementation of the Value & Sustainability Board 'Bone Health' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation.	G4 G5	A4	Executive Director of Finance	Q2 (No Update provided during this reporting cycle)
4G.2	Review current progress with the implementation of the Value & Sustainability Board Diabetes' High Value High Impact (HVHI) pathway and produce a proposal to support further implementation. This is to be managed as part of the Primary Care IMTP plans.	G4 G5	A4	Executive Director of Finance	Q3 (No Update provided during this reporting cycle)

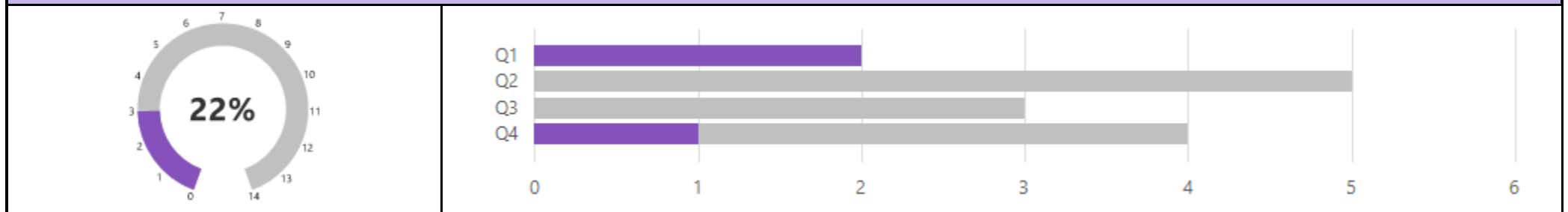
4G.3	Address variation reported in the National Outcomes Framework and National Clinical Audit and Outcome Review Programme.	G4	A4	Executive Director of Finance	Q4 (Moderate Delivery Confidence)
4G.4	Develop a Clinical Variation programme to deliver against the core thematic, which have been identified through the national Clinical Variation & Service Reconfiguration Group, with a particular focus on reducing unwarranted clinical variation, minimising waste, improving efficiency and ensuring sustainable service configuration.	G4 G5	A4	Executive Director of Finance	Q1 (Low Delivery Confidence)
4G.5	Develop a Non-Pay & Procurement programme to deliver against the core thematic, which have been identified through the national Non-Pay & Procurement Value & Sustainability Group, with a particular focus on reducing clinical variation to maximise benefits in relation to price and product standardisation.	G1 G6	A1	Executive Director of Finance	Q1 (Complete)
4G.6	Develop a Medicines Management programme to deliver against the seven priority areas, which have been identified through the Directors of Pharmacy's Medicines Value and Sustainability Delivery Assurance Group and endorsed by the NHS Value and Sustainability Board.	G1 G6	A1	Executive Director of Finance	Q1 (Complete)
4G.7	Develop a CHC programme to deliver against the seven priority areas, which have been identified through the national CHC Value & Sustainability Group.	G1	A1	Executive Director of Finance	Q1 (Complete)
4G.8	Develop a 'bottom-up' value programme for staff to register their value ideas/initiatives, with advice, guidance and resource provided where appropriate to mature ideas into delivery.	G4 G6	A3 A5	Executive Director of Finance	Q4 High Delivery Confidence
4G.9	Develop a robust benefits framework for the programme, which allows for the effective measurement of activity and resources linked to VBHC (clinical staff, administrative staff, budgets,	G5	A4	Executive Director of Finance	Q1 (Complete)

	buildings, energy etc) to improve patient outcomes, patient experience and resource efficiency to ensure value and patient-centred care.				
4G.10	Use Value Based Health Care (VBHC) guidance for designing services, responding to key population level intelligence including OECD PaRIS report 2025 - Value in Health and through service level Patient Reported Outcome Measurements (PROMs), Patient Reported Experience Measurements (PREMs) and social value measures for procurement. This is to be managed as part of the Clinical Services Plan	G5	A4	Executive Director of Finance	Q4 (No Update provided during this reporting cycle)
4G.11	As part of our refined planning process, we will utilise the value-based approach that provides the discipline to stop low-value activity, shifting finite resources to prevention and earlier access, community-based care, better-value interventions, and supporting people to manage more of their own health. All of our major investment and dis-investment decisions should therefore be assessed according to their impact on outcomes, experiences, and the value generated from resources used. This is to be overseen by the Planning Team.	G3 G5	A3 A4	Executive Director of Finance	Q4 (No Update provided during this reporting cycle)
4G.12	Deliver a refreshed Value & Sustainability programme that realises the agreed recurrent savings target for 26/27, aligned with the national value and sustainability structure and associated priorities and which also ensures that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis.	G1 G2	A1 A2	Executive Director of Finance	Q4 High Delivery Confidence

Priority:	4H Quality				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to consistently deliver safe, effective and high-quality care due to challenges in embedding the Quality Management System (QMS), organisational change, and ongoing operational challenges particularly within UEC and Planned care , workforce and financial pressures . This may result in variability in care quality, increased patient harm, failure to meet statutory and regulatory requirements, and reduced confidence from patients, staff and stakeholders.					
Accountable:	Executive Director of Nursing				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
• Development and implementation of a Quality Management System (QMS) and maturity framework (4H.1) • Development of a Health Board-wide Quality Accreditation Framework (4H.2) • Redesign and strengthening of quality governance framework including quality issues log (4H.3) • Implementation of audit programmes and NICE compliance improvements (4H.4–4H.5) • Delivery of national patient safety strategy and digital safety programmes (4H.6–4H.7) • Implementation of Listening to People Regulations and ward accreditation programmes (4H.8–4H.9) • Implementation of infection prevention and safety improvement plans (4H.10–4H.12) • Development of organisational learning systems and repository (4H.13) • Oversight of national quality standards and best practice (4H.14)		G1: QMS not yet fully embedded across all services G2: Limited dedicated capacity to sustain QMS and quality improvements G3: Risk of reduced focus on quality during organisational change G4: Ongoing operational pressures particularly in UEC and planned care is impacting ability to prioritise quality improvement G5: Inconsistent application of quality governance processes across services G6: Limited integration of learning and improvement across the organisation	Management Assurance • IMTP monitoring of 4H deliverables (4H.1–4H.14) • QMS maturity metrics and reporting • Quality governance reporting and quality issues log • Audit programmes and compliance reporting • Performance indicators (infection rates, incidents, complaints, mortality data) Major change programme in place for both UEC and planned care improvement CIVICA patient experience data measured and monitored Risk & Compliance Assurance • Compliance with national quality frameworks and standards (e.g. NICE, Patient Safety Strategy) • Monitoring against statutory requirements including Duty of Quality and Duty of Candour • Infection prevention and control performance reporting	A1: Limited assurance that QMS is fully embedded and consistently applied A2: Limited visibility of sustainability of quality improvements over time A3: Limited assurance of impact of organisational change on quality outcomes A4: Limited evidence linking quality improvement activity to patient outcomes A5: Limited assurance of consistency of quality governance and oversight across services A6: Limited assurance that organisational learning is embedded and driving improvement	

		Integrated quality reports reported through QSE to Board Independent Assurance • Welsh Government oversight and Special Measures framework • Health Inspectorate Wales (HIW) inspections and reviews • External audit and regulatory reviews		

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4H.1	Develop a comprehensive organisational plan, aligned to Foundations for the Future, to embed the QMS into all core business processes and fully onboard every service to the QMS Maturity App, enabling systematic identification and response to fragile services.	G1 G2	A1 A2	Executive Director of Nursing	Q2 (Low Delivery Confidence)
4H.2	Develop and begin implementation of a Health Board-wide Quality Accreditation Framework aligned to QMS and regulatory standards, recognising and incentivising excellence.	G1 G5	A1 A5	Executive Director of Nursing	Q4 (Moderate Delivery Confidence)

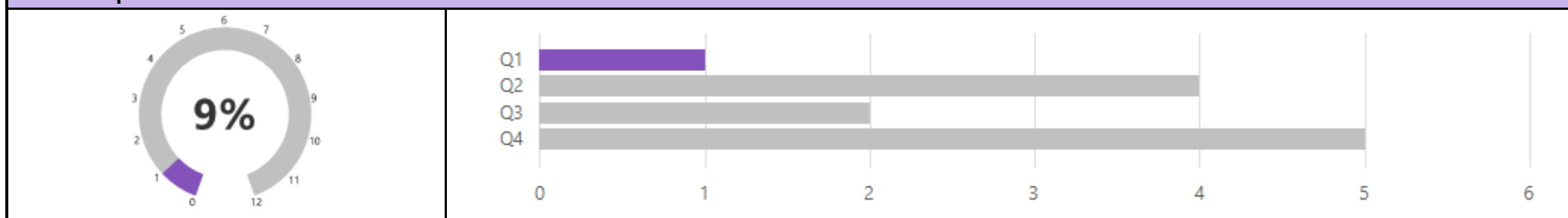
4H.3	Re-design and implementation of quality governance framework to include implementation of quality issues log.	G5 G6	A5 A6	Executive Director of Nursing	Q2 High Delivery Confidence
4H.4	Deliver on findings of internal audit of NICE compliance by focussing on areas where NICE guidance not implemented with clear process of reviewing impact and addressing if significant risk.	G5	A2	Executive Director of Nursing	Q1 (Complete)
4H.5	Develop programme of Tier 2 audits based on current quality risks.	G5	A2	Executive Director of Nursing	Q1 (Complete)
4H.6	Develop programme of work to address priority programmes and actions within National Patient Safety Strategy including key performance indicators to measure improvement.	G4 G5	A4	Executive Director of Nursing	Q4 (No Update provided during this reporting cycle)
4H.7	Develop a programme of work and governance framework to address digital safety.	G5	A5	Executive Director of Nursing	Q3 (No Update provided during this reporting cycle)
4H.8	Refresh of NatSSIPs programme to address recent Never Events and reintroduce a revised ward accreditation programme in line with the QMS methodology.	G5 G6	A4 A6	Executive Director of Nursing	Q2 High Delivery Confidence
4H.9	Implement the new Listening to People Regulations and deliver on the 40% national performance target.	G4	A4	Executive Director of Nursing	Q2 High Delivery Confidence
4H.10	Meet the nationally set Infection Prevention trajectories and reduce the incidents of infections (including C-Diff and E.Coli) and associated harm, through implementation of the IPC improvement plan.	G4	A4	Executive Director of Nursing	Q3 (No Update provided during this reporting cycle)

4H.11	We will reduce severe and catastrophic incident numbers and monitor improvement and learning through the Integrated concerns Hub.	G6	A6	Executive Director of Nursing	Q2 (Low Delivery Confidence)
4H.12	We will reduce the number of avoidable falls and HAPU through continuing to implement the actions identified in the associated improvement groups.	G4	A4	Executive Director of Nursing	Q3 High Delivery Confidence
4H.13	We will fully implement the learning repository and have clear outcomes with regard to robust and sustained organisational learning and how it positively impacts outcomes.	G6	A6	Executive Director of Nursing	Q4 (Complete)
4H.14	Provide direction and oversight through the organisation's Quality governance for the application of appropriate best practice within the national Quality Statements - the ones not covered elsewhere in the plan are: Care of the critically ill, Respiratory Disease, Heart conditions, Kidney Disease, Liver Disease, Musculoskeletal health, Neurological conditions, Stroke, Infection prevention and control, Osteoporosis and bone health.	G5 G6	A5 A6	Executive Director of Nursing	Q4 (Low Delivery Confidence)

Priority:	4I Environment and Estates				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a safe, efficient and sustainable estate and environment due to external uncertainty, competing priorities and limited resources to deliver climate adaptation and estate transformation programmes. This may result in deterioration of estate quality, reduced service resilience, inability to support service transformation, and failure to meet environmental and decarbonisation targets.					
Accountable:	Director of Environment & Estates				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Development of long-term estate plans for major infrastructure and business continuity schemes (4I.1) • Progression of key capital projects and estate developments (4I.2–4I.3) • Implementation of safety improvement		G1: Dependence on external strategic direction (e.g. Welsh Government/Senedd decisions) G2: Limited capacity and prioritisation to deliver climate adaptation and decarbonisation programmes	Management Assurance • IMTP monitoring of 4I deliverables (4I.1–4I.12) • Estates Programme governance and reporting • Capital programme monitoring	A1: Limited assurance over impact of external strategic changes on estate planning A2: Limited visibility of delivery progress of climate adaptation and decarbonisation plans	

programmes (e.g. anti-ligature) (4I.4) • Development of revised Estates Strategic Plan aligned to 10-year strategy and CSP (4I.5) • Engagement on future estate redevelopment and planning (4I.6) • Programmes to improve estate efficiency and utilisation (4I.7–4I.9) • Development and implementation of climate adaptation and decarbonisation plans (4I.10–4I.12)	G3: Ageing estate and backlog maintenance challenges G4: Limited availability of capital funding and competing investment priorities G5: Incomplete alignment between estate strategy and service transformation plans G6: Variable estate utilisation and efficiency across sites	and delivery reporting • Estate performance metrics (utilisation, maintenance backlog, efficiency) Risk & Compliance Assurance • Compliance with estate safety standards and statutory requirements • Monitoring against NHS Wales Decarbonisation Strategic Delivery Plan • Oversight of capital planning and prioritisation processes Independent Assurance • Welsh Government oversight of capital programmes and estate strategy • External audit and inspection (e.g. estates, safety compliance) • Benchmarking against NHS Wales estate performance and sustainability metrics	A3: Limited assurance of long-term sustainability of estate within funding constraints A4: Limited evidence linking estate improvements to service outcomes A5: Limited assurance that estate strategy is fully aligned to service transformation plans	

Plans to improve control :



Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4I.1	Develop long-term plans for the delivery of the key estates projects including 1) Business continuity scheme for Ysbyty Gwynedd, 2) Electrical infrastructure replacement scheme for Ysbyty Glan Clwyd, 3) Business Continuity scheme for Wrexham Maelor Hospital, 4) Replacement helipads at Ysbyty Gwynedd and Ysbyty Glan Clwyd.	G3 G4	A3	Director of Environment & Estates	Q4 High Delivery Confidence
4I.2	Royal Alexandra Hospital (Rhyl) Phase 2 – Complete the schedule of accommodation and strategic outline case	G4	A3	Director of Environment & Estates	Q4 (Low Delivery Confidence)
4I.3	Plas Gororau (Wrexham) Phase 2 - Commence construction.	G4	A3	Director of Environment & Estates	Q1 (Complete)
4I.4	Develop and commence implementation of an organisation wide anti-ligature programme.	G3	A4	Director of Environment & Estates	Q2 (Low Delivery Confidence)
4I.5	Agree the approach to developing a revised Estates Strategic Plan, in line with the Health Board's 10-year Strategy and Clinical Services Plan.	G5	A5	Director of Environment & Estates	Q4 (Moderate Delivery Confidence)
4I.6	Commence engagement regarding the potential future redevelopment of the Wrexham Maelor Hospital site.	G1 G5	A1 A5	Director of Environment & Estates	Q3 (Moderate Delivery Confidence)
4I.7	Ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate and the reduction in the number of leases.	G6	A4	Director of Environment & Estates	Q2 (Moderate Delivery Confidence)
4I.8	Implement a computer aided facilities management system to support the management of the estate and the implementation of AI based energy management applications.	G2 G6	A2	Director of Environment & Estates	Q2 High Delivery Confidence

4I.9	Development of a pan-BCU approach to managing car parking for staff and patients.	G6	A4	Director of Environment & Estates	Q2 (Moderate Delivery Confidence)
4I.10	Develop a BCUHB Climate Adaptation plan aligned with the NHS Wales Decarbonisation Plan and in parallel implement estate decarbonisation programmes.	G2	A2	Director of Environment & Estates	Q4 (Low Delivery Confidence)
4I.11	Maximising the access to grant funding through the Refit Framework to deliver a programme of works to support carbon reduction.	G4	A3	Director of Environment & Estates	Q3 (Moderate Delivery Confidence)
4I.12	Commence construction of the photo-voltaic array at Ysbyty Gwynedd as part of adopting renewable energy technologies.	G2	A2	Director of Environment & Estates	Q4 (Low Delivery Confidence)

Priority:	4J Workforce				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a sustainable, skilled and resilient workforce due to insufficient capacity and capability for workforce planning, continued reliance on agency staffing, and operational pressures. This may result in reduced workforce stability, increased costs, inability to deliver safe and effective care, and failure to support service transformation and strategic objectives.					
Accountable:	Executive Director of People Services & OD				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Review and improvement of consultant job planning and workforce productivity (4J.1) • Reduction of agency spend through workforce planning and control frameworks (4J.2–4J.3) • Implementation of sickness absence improvement plans (4J.4) • Delivery of Culture, Leadership and Engagement programme (4J.5–4J.6) • Implementation of strategic workforce planning aligned to service transformation (4J.7)		G1: Insufficient dedicated capacity and capability to deliver job planning sustainably G2: Limited capacity and systems to reduce agency usage and reliance G3: Workforce planning not fully embedded across all services G4: Operational pressures impacting delivery of workforce initiatives G5: Limited workforce data integration and visibility for planning decisions	Management Assurance • IMTP monitoring of 4J deliverables (4J.1–4J.8) • Workforce performance metrics (turnover, agency spend, sickness absence, job planning compliance) • Workforce planning and People & Culture Committee reporting • Delivery of workforce improvement programmes and action plans	A1: Limited assurance that job planning improvements are sustainable and fully embedded A2: Limited visibility and assurance of sustained reduction in agency usage and spend A3: Limited assurance that workforce planning is consistently applied across	

• Compliance with Social Partnership Duty and reporting requirements (4J.8)	G6: Culture and engagement improvements not yet fully embedded	Risk & Compliance Assurance • Compliance with Welsh Health Circulars and workforce policies • Monitoring against national workforce targets and frameworks • Oversight through governance committees (People & Culture, Finance, Performance) Independent Assurance • Welsh Government oversight of workforce performance and IMTP delivery • External benchmarking against NHS Wales workforce indicators • Audit and review of workforce planning and agency reduction programmes	organisation A4: Limited evidence linking workforce initiatives to improved service delivery outcomes A5: Limited assurance of workforce sustainability within financial and operational constraints	

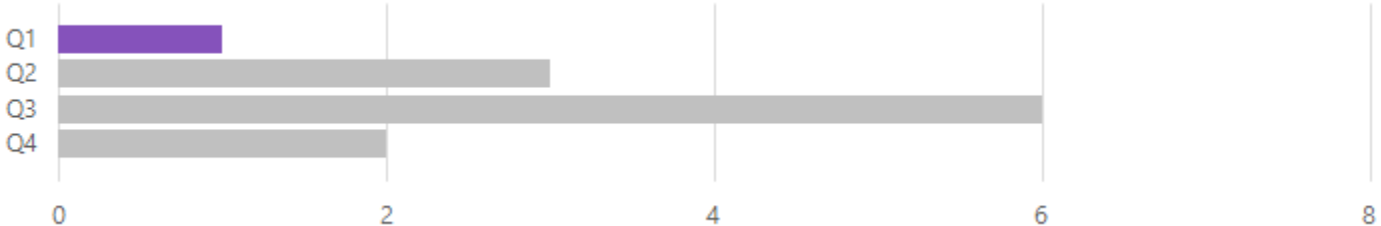
Plans to improve control :					
					
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4J.1	Review of Consultant job plans – Operational Services to be targeted to reach >90% to ensure improved workforce productivity and alignment to demand and capacity. This will be measured	G1 G3	A1 A3	Executive Director of People Services & Organisational Development	Q2 (No Update provided during this

	through the Job Planning Dashboard and follows on from work undertaken in 2025/26.				reporting cycle)
4J.2	Review of agency expenditure. Operational Services to be targeted with a 30% reduction in agency expenditure. All services to be targeted with no off-contract agency use and not Admin and Clerical, Estates and Ancillary and Health care Support Worker agency use through effective workforce planning, optimising the benefits of the newly insourced medical bank resource and management controls. This will be measured through the Value & Sustainability (V&S) Group.	G2 G3	A2 A3	Executive Director of People Services & Organisational Development	Q2 (No Update provided during this reporting cycle)
4J.3	Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular by continuing to reduce agency requirements and incentivise substantive positions through flexible working, effective rostering and employee health and wellbeing programmes of work.	G2	A2 A5	Executive Director of People Services & Organisational Development	Q4 (No Update provided during this reporting cycle)
4J.4	Work with operational and corporate directors to implement and deliver the Health Board's sickness absence delivery plan to improve workplace attendance levels and to meet national sickness absence and local stretch targets. Progress will be monitored through the People and Culture Committee.	G4	A4	Executive Director of People Services & Organisational Development	Q4 (No Update provided during this reporting cycle)
4J.5	Implement and deliver the year 1 actions from the Culture, Leadership and Engagement 3-year Improvement plan 2026-29.	G6	A4 A5	Executive Director of People Services & Organisational Development	Q4 (Moderate Delivery Confidence)
4J.6	Review and respond to staff survey feedback to support an improvement in staff engagement and satisfaction.	G6	A4	Executive Director of People Services & Organisational Development	Q4 (No Update provided during this reporting cycle)

4J.7	Implement in partnership strategic workforce planning across the organisation, improving alignment with Clinical Service Plans, use of technology, Financial Plans linked to IMTP objectives. Progress will be measured through the Foundations for the Future programme board. Plans will proactively identify any workforce capacity, skills and talent gaps and set out initiatives to address these in order to meet organisational objectives.	G5 G5	A3 A5	Executive Director of People Services & Organisational Development	Q4 High Delivery Confidence
4J.8	Prepare the annual social partnership report outlining what the Health Board has done to comply with the Social Partnership Duty, agreeing it with Trade Unions and submitting to the Social Partnership Council (SPC) as soon as possible after the end of the financial year.	G3	A3	Executive Director of People Services & Organisational Development	Q4 (No Update provided during this reporting cycle)

Priority:	4K Finance & Commissioning				
Strategic Threat and Risks: Threat: There is a risk that the Health Board is unable to deliver a financially sustainable position and effective commissioning arrangements due to organisational change, external financial pressures, and limited capacity within services. This may result in failure to achieve a balanced financial plan, ineffective allocation of resources, reduced value from commissioned services, and an inability to deliver strategic service transformation aligned to population needs.					
Accountable:	Executive Director of Finance				
Primary risk controls:		Gaps in control:	Sources of assurance:	Gaps in assurance:	Assurance Rating
Implementation of financial control environment and governance arrangements (4K.1) • Establishment of accountability agreements for budget holders (4K.2) • Delivery of Value & Sustainability programme to support financial recovery (4K.3) • Monitoring and analysis of investment shifts towards primary and community care (4K.4) • Development of commissioning strategic approach and partnerships (4K.5) • Implementation of integrated commissioning framework and governance arrangements (4K.6)		G1: Organisational change impacting financial governance and accountability G2: Challenging financial environment limiting ability to shift investment to priority areas G3: Limited capacity within services to support commissioning reviews and decision-making G4: Incomplete maturity of commissioning frameworks and processes G5: Limited integration between	Management Assurance • IMTP monitoring of 4K deliverables (4K.1–4K.13) • Financial performance reporting and budget monitoring • Value & Sustainability Programme reporting • Commissioning and contract performance monitoring Risk & Compliance Assurance	A1: Limited assurance that financial plan delivery is sustainable over medium term A2: Limited visibility of impact of organisational changes on financial performance A3: Limited assurance of capacity and capability to deliver commissioning changes A4: Limited evidence that commissioning decisions are delivering improved value and	

• Annual review of commissioned services and contracts (4K.7–4K.8) • Strengthening commissioning performance monitoring and oversight (4K.10–4K.11) • Engagement with Joint Commissioning Committee and national partners (4K.12) • Development and delivery of financial recovery plan (4K.13)	financial planning, service planning and commissioning G6: Variability in contract management and performance monitoring arrangements	• Compliance with Standing Financial Instructions and governance frameworks • Oversight of financial control measures and accountability agreements • Monitoring against Welsh Government financial requirements Independent Assurance • Welsh Government oversight of financial plans and IMTP delivery • External audit and financial assurance reviews • Benchmarking and national commissioning and financial frameworks	outcomes A5: Limited assurance of alignment between financial planning, commissioning and strategic priorities	

Plans to improve control :					
					
Ref	2026/2027 Deliverable	Improves Gaps in Control	Improves Gaps in Assurance	Executive Owner	Status of Action
4K.1	Maintain financial control measures from start of financial year, with a view to step them down as assurance and confidence is being gained in delivery of the financial plan. Particularly important due to FFTF structure changes mid-year that could	G1	A2	Executive Director of Finance	Q2 High Delivery Confidence

	otherwise cause some disruption in delivery of financial plan.				
4K.2	Contribute to the broader performance accountability agreements to ensure that budget owners are clear on their budget for the year and their accountabilities in relation to delivery within budget.	G1	A2	Executive Director of Finance	Q1 (Complete)
4K.3	Contribute to all the workstreams within the Value & Sustainability programme with a particular focus on those that are more traditionally related to financial management such as Non-Pay and ensuring there is a focus and visibility associated to savings in non-core areas and overheads to prioritise front-line services.	G2 G5	A1	Executive Director of Finance	Q2 High Delivery Confidence
4K.4	Repeat the exercise to quantify current spend on primary and community services to compare against the baseline produced in 2025/26, in order to ascertain whether the required strategic move to proportionately increasing investment into primary and community care when compared to secondary care is happening.	G2	A1	Executive Director of Finance	Q3 High Delivery Confidence
4K.5	Develop and commence implementation of a Commissioning Strategic Approach for all externally commissioned healthcare activities, that provides direction to the organisation on the role of commissioned services as part of longer-term strategic planning. Forming strategic partnerships will be an important part of the Clinical Services Plan work.	G4 G5	A4 A5	Executive Director of Finance	Q2 (No Update provided during this reporting cycle)
4K.6	Create an Integrated Commissioning Framework that includes commissioning assurance, and clarity of roles and responsibilities, ensuring that everyone across the organisation is clear on roles to enable effective commissioning with a focus on value, quality and patient outcomes.	G4	A4 A5	Executive Director of Finance	Q3 (No Update provided during this reporting cycle)

4K.7	Individual services to undertake an annual review of all their commissioned and contracted services as part of the IMTP process to ensure that the right strategic decisions are made on what the organisation should provide or commission. This should trigger de-commissioning, re-commissioning, as well as commissioning of new services where that best meets the needs of the population.	G3 G4	A3	Executive Director of Finance	Q4 High Delivery Confidence
4K.8	In advance of the annual review of all services, undertake a risk-based review of contracts to ensure they are delivering value against current population need.	G3 G6	A3 A4	Executive Director of Finance	Q3 High Delivery Confidence
4K.10	Develop robust commissioning plans for planned care services to secure additional capacity that addresses service backlogs and demand beyond internal capability. Establish and implement a comprehensive process that defines internal resource requirements and incorporates the full procurement, governance, and mobilisation pathway needed to deliver the required capacity.	G3 G6	A3 A4	Executive Director of Finance	Q3 (No Update provided during this reporting cycle)
4K.11	Complete a review of performance monitoring arrangements for all existing commissioned services, ensuring that an appropriately broad set of performance metrics are covered along with consistent periodic commissioned services partner review meetings.	G6	A4	Executive Director of Finance	Q4 High Delivery Confidence
4K.12	Work with the Joint Commissioning Committee (JCC) to develop a financially balanced plan for the delivery of specialist services for the Health Board's population. Ensure consistent and effective representation from BCU at all JCC meetings and support a constructive approach to handling challenges. Proactively engage with the JCC to contribute to:- Efficiency and productivity schemes that collaboratively manage demand and cost pressures e.g. referral management.- New clinical	G2 G5	A1 A4	Executive Director of Finance	Q3 (Moderate Delivery Confidence)

	models in relation to Emergency Ambulance Services.- Save a Life Cymru (SALC) defibrillator awareness. • New air bases for the Emergency Medical Retrieval Service (EMRTS). • Adult Critical Care Transfer Service (ACCTS) in line with the Health Board's emerging Clinical Services Plan. Non-Emergency Patient Transport Service (NEPTS) transformation. Neonatal Transport (CHANTS) & Major Trauma pathways. Clinical engagement and partnership in Sexual Assault Referral Centres (SARC). • Improved commissioning and strategic partnerships with hospices and the Voluntary Sector. A strategic review of Mental Health, Learning Disabilities and Vulnerable Groups commissioning. Strategic reviews and deep dives relating to specialised services commissioned services across Cancer & Blood, Cardiac, Kidney, Neurosciences and Women & Children's services.				
4K.13	Prepare and commence execution of a robust and sustainable recovery plan, as detailed within Standing Financial Instructions, following submission of an in year deficit outturn	G1 G2	A1 A2	Executive Director of Finance	Q3 (No Update provided during this reporting cycle)

BAF Risk	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range)	Status of Actions at mapping	Strategic Intent Priority	Mapped deliverable	BAF 26_01 – Failure to deliver Improved population health and reduced inequalities	BAF 26_02 – Failure to deliver enhanced coordination of care for people with long term conditions and improve access	BAF 26_03 – Failure to Improve access, outcomes and experience	BAF 26_04 Failure to deliver and create a modern, people centred health care system that is future focused
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Senior Posts for reviewing Digital architecture and EHR. Funding for Architecture and EHR Teams is temporary and has been sourced from various non-recurrent budgets. Teams likely to have to stand down from April 2025 onwards and therefore progress halted (subject to budget setting process). NB. This is a 3-to-5-year piece of work. Activity which is required by 31st March 2025 will be completed. Senior Architecture posts in place but funded non-recurrently. These are resolving clinical system integration, which will also halt on the 31/03/2026 should recurrent funding not be secured.	Overdue	4D – Digital, Data & Intelligence 4C – Clinical Services Planning	• 4D.19 Review and update Digital Roadmap • 4D.15 Decommission legacy unsupported systems • 4D.16 Strategic Outline Case for digitisation of patient records • 4C.1–4C.4 CSP methodology & alignment of digital requirements				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Roll-out of key priority EHR transformation projects. No funding from April 2025 onwards, to progress EHR Programme and other augmentation projects to improve the current digital environment. NB. This is a 3-to-5-year piece of work. The Electronic Health Record (EHR) – Acute and Community, Outline Business Case (OBC) first draft was handed over from the external consultants in March 25, the OBC has been updated following engagement with legal, finance, procurement and DDaT. Currently, there is no funding to progress this further, and Welsh Government have asked all Health Boards to pause while they agree a national approach. The Mental Health EHR is progressing with the procurement evaluation complete. Once assurance activities have been completed the next step will be to finalise the Full Business Case (FBC) and award contract following board approval. A strategic outline case for the scanning plan is being prepared, with anticipated submission for formal approval in April 2026 via the appropriate governance board.	Progressing	4D – Digital, Data & Intelligence 3D – Mental Health & Learning Disabilities	• 4D.19 Digital Roadmap alignment to 10-year Strategy & CSP • 4D.11–4D.12 Population Health Management datasets • 3D.9 Mental Health EHR transformation			X	X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Transformation of the DDaT Operating Model. Proposals for 2025/26 onwards are being progressed for consideration. Due to significant digital inflation, plans have been put forward and are currently being considered in line with other inflationary pressures. Bids for growth are being revised to align with IMTP Planning processes Anticipated position and due date will be 30th April 2026	Delayed	4D – Digital, Data & Intelligence 4A – Foundations for the Future	• 4D.1 Demand & capacity tools for digital • 4D.19 Digital Roadmap alignment • 4A.1–4A.7 Foundations for the Future: new operating model design				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Proposals, (repeated from previous years) for 2025/26 onwards are being progressed for consideration. Cost Pressures and Growth proposals submitted to Executive Team for consideration. Only RIGA 1 additional funding resource received which doesn't take into consideration the required cost pressures or growth initiatives. Will continue to review funding gaps and available schemes.	Overdue	4K – Finance & Commissioning 4G – Value & Sustainability	• 4K.1 Financial control measures • 4K.2 Accountability agreements • 4G.12 Recurrent savings realisation • 4G.3 Address clinical variation & resource efficiency				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Expand the implementation of the Digital Training Academy enhancing the skills and understanding of clinical and non-clinical systems and Q365 tools.	Progressing	4D – Digital, Data & Intelligence	• 4D.13 Digital Skills Assessment • 4D.14 Data literacy & "Making Data Count" training offer				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Implement and ensure Executive Decision and oversight of the Digital Prioritisation of projects and programmes in line with IMTP and Funding Arrangements.	Progressing	4D – Digital, Data & Intelligence 4B – Strategy & Planning	• 4D.19 Roadmap integration with Strategy & CSP • 4B.1–4B.3 Strategy Discovery & Design phases				X
BAF24-02: Not Delivering Strategic Development and Digital Transformation	Develop phase 2 of the Clinical Services Plan for implementation - a blueprint for services across North Wales	Progressing	4B – Strategy and Planning 4C - Clinical Services Planning	• 4B1, 2, 3 & 4B5 – 11 • 4C1, 2, 3, 4				X
BAF24-03: Not Achieving Long Term Financial Sustainability	Decarbonisation reporting of key objectives through to Committee (PPHP) completed, articulating goals and objectives through to Health Board. Revised NHS Wales decarb plan was published in 2025 and is currently under review. Health Board then to draft plan and an action plan.	Delayed	4I – Environment & Estates	• 4I.10 Development of BCUHB Climate Adaptation Plan • 4I.11 REFIT / carbon-reduction grant funding access • 4I.12 Renewable energy implementation (e.g., PV array) 4I.7 4I.5				X
BAF24-03: Not Achieving Long Term Financial Sustainability	Ongoing development of Estates strategy to be informed by completion of a reduced facet survey (to reflect unallocated budget), a register of assets and most importantly clinical strategies (this review of estates is likely to take 12 months) and will be used to drive estate utilisation and rationalisation. At present, this is delayed pending clinical service plans.	Delayed	4I – Environment & Estates 4C – Clinical Services Planning	• 4I.5 Revised Estates Strategic Plan aligned to 10-year Strategy & CSP • 4I.7 Estate utilisation & rationalisation improvements • 4C.1–4C.4 Clinical Services Plan methodology, prioritisation & alignment				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Prioritise implementing the workforce planning framework across the Health Board, with initial prioritisation for 'challenged services'. This action is on-going as services become familiar with the templates and the governance arrangements for the framework are embedded throughout 2026/27.	Overdue	4J – Workforce 4F – Education Partnerships	• 4J.7 Strategic Workforce Planning implementation • 4J.1–4J.4 Workforce productivity, job planning & sickness absence reduction • 4F.9–4F.10 Governance alignment of education & workforce planning				X

BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Support the implementation of measures to aid reducing agency usage and improve value and sustainability of workforce. Progress has been made in some staff groups and now a particular focus on M&D agency is needed throughout 2026/27. The action end date will need to be extended to the end of Q4 (from 31/03/2026).	Delayed	4G – Value & Sustainability 4J – Workforce	• 4G.1–4G.12 Value & Sustainability (clinical variation, workforce efficiencies) • 4J.2–4J.3 Reduce agency spend & improve workforce sustainability • 4J.7 Strategic Workforce Planning implementation				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Implementing Values and Behaviours Framework. The V&B framework has been implemented, additional actions will be agreed to further embed and enhance its adoption, these will be added to the BAF in the coming weeks.	Overdue	4A – Foundations for the Future 4J – Workforce 4C – Clinical Leadership	• 4A.1 Culture, Leadership & Engagement programme • 4J.5–4J.6 Culture, engagement & behavioural improvement actions • 4C.9–4C.10 Interprofessional team working & leadership behaviours				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Embedding Integrated Leadership Development Framework.	Delayed	4C – Clinical Services Planning & Leadership 4A – Foundations for the Future 4J – Workforce	• 4C.5–4C.8 Clinical leadership roles, training & capability • 4A.1 Leadership culture & organisational development • 4J.5 Leadership & engagement improvement programme				X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Developing Anchor Institute Framework – ongoing, draft Anchor Charter developed with partners and being formally discussed at regional wellbeing and anchor charter event on 19.03.26.	Overdue	1C – Health Inequalities / Anchor Institute Partnership & Regional Collaboration	• 1C.6 Anchor principles & missions implementation (Environment, Communities, Housing, Employment, Food, Learning, Creative & Active Lifestyles) • Section 5 – Working with Partners: strengthening regional collaboration & social value frameworks	X			
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Citizen Engagement Plan being reviewed – the draft principles and framework developed – Co-production, Engagement and Consultation Toolkit developed, Principles and Framework to be discussed at Executive Group Meeting before end of April 2026.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4A.12 Partner engagement in operating model • 4B.1–4B.4 Embedding engagement into IMTP & Strategy processes		X		X
BAF24-04: Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Communications and engagement plan November 2025 to post Senedd election 2026 addressing progress to date and areas of Board focus in the months ahead – plan in development, overseen by the Chief Executive Officer.	Progressing	3B – Citizen Engagement 4A – Foundations for the Future 4B – Strategy & Planning	• 4B.2–4B.3 Strategic design & delivery – embedding public voice 4B.4, 4B7		X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Learning Repository Development – A Project Group oversees governance, strategic alignment, and accountability for the wider rollout by 31st April 2026. (Delayed from 31/11/2025)	Delayed	4H – Quality	• 4H.13 Implementation of learning repository & embedding organisational learning				X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Harms review process to be approved for planned care activity.	Overdue	3B – Planned Care 4H – Quality 4C – Clinical Services Planning	• 4H.1–4H.3 Quality Management System & governance framework development		X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Diabetes Pathway Programme – completion of case for change and next steps agreed - delay in appointing Clinical Lead however this has now gone out for expressions of interest. There have been some revisions to the plan as a result and also in keeping with wider priority programmes including Primary Care. Completion of the Diabetes Pathway Programme case for change has been completed however the overall implementation of the programme has been delayed in 25.26 due to dependencies, including the appointment of a Clinical Lead. The plan has been revised to align with wider priorities, and the completion date has moved from July 2025 to December 2026.	Delayed	1B – Disease Prevention 2A Primary Care 2B Community by Design 4G – Value & Sustainability 4C – Clinical Services Plan 4D – Population Health Management	• 1B.4–1B.7 Diabetes pathway (care processes, variation reduction, best practice) 2A.5 integrated primary & Community care 2B.1 -4 Community by Design (mapping, planning, delivery) • 4G.2 High Value/High Impact Diabetes Pathway • 4C.1-4 CSP alignment with disease pathways 4D.11-12 Population health intelligence	X	X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Deliver Primary Care based approaches to improving the compliance with NICE guidance. Awaiting update and revised date from Primary Care leads.	Overdue	2A – Primary Care 2B – Community by Design 1B – Disease Prevention 4H – Quality 4C – Clinical Services Plan	Incomplete improvement in NICE compliance; requires strengthened primary-community-secondary integration and clearer pathways.	X	X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Prevention embedded in Board Major Programmes.	Overdue	1A–1D – Prevention & Inequalities 4B – Strategy & Planning 4C – Clinical Services Plan 4G – Value Based Healthcare	• 1A–1D Prevention, Health improvement, Health Inequalities, Health Protection • 4B.1–4B.3 Strategy & IMTP alignment • 4C.1 CSP methodology – embedding prevention & PHM 4G.10 Respond to key population health intelligence	X			X

BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Development of Clinical Services Plan and Health Board Strategy recognises prevention as component part. Development of the Clinical Services Plan and Health Board Strategy, which incorporates prevention as a key component, has been delayed due to dependencies on preceding work. The completion date has moved from March 2025 to December 2026.	Delayed	1A-D Prevention & inequalities 4C – Clinical Services Planning 4B – Strategy & Planning 4D – Population Health Management 4I – Environment & Estates	1A-D Prevention, Health improvement, Health Inequalities, Health Protection • 4C.1–4C.4 Clinical Services Plan development & prioritisation • 4B.1–4B.3 10-year Strategy Discovery/Design/Delivery 4D.11-12 Population health intelligence • 4I.5 Estates Strategy alignment to CSP	X				X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Increased pathways with Primary care. Primary Care Service Transformation Delivery group has progressed with work completed outlining system challenges to inform next steps. On track but will be ongoing.	Delayed	3D MHL D 2A – Primary Care 4C – Clinical Leadership	• 3D.3 - Agree and develop with partners • 2A.5 Integrated primary & community pathways • 4C.9–4C.10 Interprofessional working		X		X	X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Electronic Health Record programme with MHL D as early adopter. Procurement concluded - assurance activity underway for award of contract. Implementation will be impacted by contract award timescales; this may impact the control completion date, but measures are being into place to mitigate this.	Overdue	4D – Digital, Data & Intelligence 3D – Mental Health & LD	• 4D.19 Digital Roadmap • 4D.6–4D.8 Coding, AI & data quality improvements • 3D.9 MHL D EHR programme rollout			X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Enhanced Savings plans. OOA/ CHC remain the well documented risks here for delivery, but plans are progressing well.	Overdue	3D MHL D 4G – Value & Sustainability 4K – Finance & Commissioning	3D.5 - Deliver a material reduction 4G.1–4G.12 Value & Sustainability Programme 4K.1–4K.3 Financial control & commissioning improvements			X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Capping OOA bed utilisation	Overdue	3D – Mental Health & LD 4G – Value & Sustainability	3D.5 Reduction in out-of-area placements • 4G.12 Financial sustainability & reducing unwarranted cost variation			X		X
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Continued implementation of waiting list protocol to ensure patients are supported whilst waiting.	Progressing	3D MHL D	3D.3 agree & develop with partners a phased open access MH service model			X		
BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Alignment with Learning Disabilities national programme- Improving Care Improving lives review.□ The LD transformation programme covers ECRS, Inpatient and Community Services and is fully aligned to the NHS P&I National improvement works. Improvements are project managed through service and divisional governance as well as the national programme. Progress to date includes successful roll out and uptake of Paul Ridd disability awareness training across BCU (not just LD services), introduction of the Health Equalities Framework (HEF) outcomes measure to support identifying health inequalities for people with a learning disability.	Overdue	3D – Mental Health & Learning Disabilities 4C – Clinical Services Planning & Interprofessional Leadership	3D.6–3D.7 MHL D improvement actions including health inequalities reduction, crisis response, • 4C.1–4C.4 CSP methodology & redesign of challenged services			X		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Use of data analytics to identify high-risk populations (completed) and optimise resource allocation, as a part of workstream one, needs aligning to enhanced community care Priorities agreed for primary and community transformation led by DPH, EMD and COO.	Overdue	4D – Digital, Data & Intelligence 1B – Proactive Strategies for Prevention	• 4D.1 Demand & capacity modelling tools • 4D.11–4D.12 Population Health Management intelligence • 1B.1–1B.3 Population health & prevention roadmap	X				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Deployment of live dashboards for real-time monitoring (complete) of performance and governance metrics. Standardise data collection and reporting processes to reduce variability in decision-making. Review of various dashboards to align input criteria and date. Data quality and alignment to data dictionary review ongoing. Dashboard designs work ongoing. Design phase to be complete by 31/07/2025. Once designed, build and deployment to take place with timescale tbc. Dashboard completed and information now used in UEC programme management, further work to continue moving forward as we develop SPoA This is on track. Due date extended to 30/09/2026 from June 2026.	Progressing	4D – Digital, Data & Intelligence	4D.13–4D.14 Digital & data skills improvement 4D.6–4D.8 Coding & data quality improvements 4D.19 Digital Roadmap alignment					X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthen digital capabilities to support service teams (such as e-triage, further roll out of home adaptations particularly rural areas, single patient tracking lists). Align digital plan to UEC plans. Alignment of plans consistent with revised prioritisation. Work underway to improve digital interface with UEC. WECDs has just been updated to enhance the data collection for ED's.	Overdue	4D – Digital, Data & Intelligence	4D.19 Digital Roadmap • 4D.15–4D.16 Legacy system reduction & digital records • 4D.5 RPA & automation opportunities					X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Standardising care pathways across the Health Board. Current mapping exercise. Sits within clinical service strategy, community health pathways being rolled out for development in elective care. SPoA 'operational' phase is commencing in Q1. There are clear performance metrics and expectations assigned to the developments into 2026/27	Overdue	3A – Urgent & Emergency Care 3B – Planned Care 4C – Clinical Services Planning	3A.4–3A.12 UEC care pathway redesign • 4C.1–4C.4 CSP methodology & service redesign 3B.2 Planned care 3B.5 Planned care			X		X

BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Re-enforce specialty level planning cycle through service line demand and capacity plan across the Health Board. Reinforced with services, complete. To be evidenced in April 2026 through Plans. Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a 'planned care sprint' to improve booking of long waiters into core capacity and transfers of care to appropriate services	Overdue	Outstanding for update as at 22/05/2026	Outstanding for update as at 22/05/2026				
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Strengthened workforce planning for key areas linked to challenged services.	Overdue	4J – Workforce 4A – Foundations for the Future	• 4J.7 Strategic workforce planning • 4J.1–4J.4 Workforce productivity controls • 4A.1 Leadership, culture & engagement improvement				X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Telehealth care to strengthen out of hospital care including home systems and video facilitated care forms workstream 1 or 4 for UEC.	Overdue	2A – Primary Care 1B – Prevention 4D – Digital, Data & Intelligence	2A.8 Digital innovation in primary care (NHS app, virtual care) • 1B.3 Preventive digital interventions • 4D.19 Digital Roadmap	X	X		X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Continued efforts to further strengthen collaboration with local authorities and voluntary sectors for integrated care delivery models. Milestones to be reported. Operational workshop to be held in May with health & Social care partners to discuss development of a 12 month plan for implementation	Overdue		Outstanding for update as at 22/05/2026				
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Incorporate public health needs analysis to service planning (such as deprivation links to access for UEC, Planned Care, CAMHS and Womens services).	Overdue	1B.1–1B.3 PHM intelligence • 4B.1–4B.3 Strategy Discovery/Design/Delivery • 3A.1–3A.3 UEC prevention & falls pathways 4C.1–4C.4	• 1B – Population Health 4B – Strategy & Planning 4C Clinical Services Plan 3A – UEC	X		X	X
BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Regional improvement approach for Child and Adolescent Mental Health (CAMHS)and Childrens Neurodevelopmental Services. CAMHS Improvement Plan revised for 2026/27 to sustain delivery of the Mental Health Measure access targets which the HB achieved in 2026/27 for assessment and intervention. The Childrens ND 3-year improvement plan has been agreed with RPB to implement a needs-led Childrens ND delivery model across health, social care and education. Confirmation of WG funding allocation (£2m) 26-27 for ND assessments, received in April. Approval from Exec Committee & PFIG subsequently confirmed for the continued use and extension of the private provider contract for children's ND assessments to support delivery against WG expectations for 2026/27.	Overdue	3E – CAMHS & ND 3D – MHLd 4C – Clinical Leadership & CSP 1A - Preventative Approaches to Health & Wellbeing 4B - Strategy & Planning	3E.1–3E.6 CAMHS & ND redesign • 3D.9 EHR for MHLd • 4C.3 CSP alignment with challenged services 1A.3 Deliver approved Grant Funded Programmes of work (WSA) 4B.5 Draw on support for NHS P&I colleagues	X	X		X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Develop a model for Cancer Referrals and activity for single modality. Work is continuing with cancer services looking at breast pathways. Stage 1 demand for all tumour sites has been assessed against ringfenced capacity to incorporate into Referral to Treatment demand and capacity work, linked to workstream 6 of the Planned Care Programme. Due to operational challenges and the complexity of cancer pathways and associated data, current focus is on short term operational forecasting and we will with colleagues from NHS Performance & Improvement to develop longer term (annual and beyond) forecasting tools for the cancer pathways. Revised due date 30/06/2026 from 30/11/2025)	Delayed	3B – Planned Care, Cancer & Diagnostics 4D – Digital, Data & Intelligence	• 3B.7–3B.15 Cancer pathway optimisation & diagnostics modernisation • 4D.1 Demand & capacity modelling • 4D.10 Transition to cloud analytics			X	X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaborative research projects with university partners. Draft 'Research Strategy on a Page' developed with Bangor University for consideration by the BU & BCUHB Strategic Steering Group which is due to meet on 8th May 2026. Action delayed from 31/03/2025 to 31/05/2026	Delayed	4E – Research, Development & Innovation	• 4E.1–4E.5 Research, Development & Innovation strategic plan, joint appointments & academic partnerships				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen academic career pathways with universities Academic Careers Community of Interest Working Group has been established and draft framework developed. The community of Interest is to be established during 2026/27. The development of this is to be supported by focus groups and workshops approach. A paper for the consideration of Executive Committee was considered on 4th March 2026 and agreement reached regarding support pending a further paper with a business case approach describing anticipated benefits and costs. Delayed from 31/03/2025 to 31/05/2026.	Delayed	4F – Education Partnerships & Academic Careers	• 4F.7–4F.11 Academic careers framework; governance for strategic education planning; HEI partnerships				X

BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Strengthen collaboration with Higher and Further Education partners across North Wales Memoranda of Understanding have been developed with Bangor and Wrexham Universities as well as Group Llandrillo Menai and College Cambria. Signing is complete apart from CC which is expected to take place in April/May. Strategic Steering Groups are in place with Bangor, Wrexham and GLIM with arrangements to follow with CC in April/May. The collaborative partnerships will progress and mature during the course of 2026/27.	Progressing	4F – Education Partnerships & Academic Careers	• 4F.1–4F.6 HE/FE partnerships; Medical School & Dental School collaboration; MoU implementation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase R&D collaboration with industry and academic institutions. MoUs have been developed as described above. Collaborations with industry have resulted in a number of joint bid applications to i4i, Contracts for Innovation and NIHR. BCU staff have presented nationally at events such as BioWales London, Cancer innovation.	Overdue	• 4E.2–4E.5 Innovation Centre development; external funding; research activity expansion	4E – Research, Development & Innovation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Secure additional funding for healthcare innovation projects. A number of grant applications are being developed or are awaiting decision from funders. To date funding has been secured from Welsh Government Innovation and from Contracts for Innovation.	Overdue	• 4E.2 Innovation Centre & funding model • 4E.4 Growth of research studies and income	4E – Research, Development & Innovation				X
BAF24-08: Not Implementing Evidenced Based Improvement and Innovation	Increase the number of joint appointments between the Health Board and academic institutions. A number of honorary appointments have been awarded, and a joint research fellow post has been appointed to. A joint research fellow post in cardiology is in progress. We are awaiting decision regarding readvertising the joint post in cancer services.	Overdue	• 4F.7–4F.11 Academic careers pathways & joint roles • 4E.3–4E.5 Embedding research into clinical roles	4F – Academic Careers 4E – Research, Development & Innovation				X

Audit Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Diane Davies, Corporate Governance Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol **Executive Summary**

The Committee is asked to receive the outcome of its annual self-assessment and consider the draft Annual Report for 2025/26 prior to their submission to the Board. The self-assessment demonstrates that the Committee remains effective in discharging its core responsibilities and is regarded as professional, stable and well-run, with particular strengths identified in relation to committee leadership, governance processes, secretariat support, Internal Audit and Counter Fraud oversight.

The assessment also identifies opportunities to further strengthen the maturity of the Committee's assurance role. Areas highlighted include improving assurance flows between Committees, strengthening understanding and use of the Board Assurance Framework, increasing regulatory and inspection awareness and improving consistency in the quality of reports presented for scrutiny. These findings will inform the Committee's development priorities for 2026/27 and support the continued strengthening of strategic assurance provided to the Board.

The draft Annual Report demonstrates the breadth of activity undertaken by the Committee during 2025/26 and provides assurance regarding the effectiveness of governance, risk management, internal control and financial stewardship arrangements. During the year the Committee maintained oversight of financial



reporting, internal and external audit, counter fraud, policy governance, statutory compliance, ministerial directions, corporate risks, the Board Assurance Framework and implementation of key governance improvement initiatives.

The Committee also supported a number of important governance developments, including strengthened oversight of audit recommendations, improvements to risk and assurance reporting, implementation of enhanced policy governance arrangements, monitoring of the Corporate Governance Improvement Plan and development of frameworks to strengthen organisational accountability, decision-making and assurance.

Taken together, the self-assessment and Annual Report provide assurance that the Committee has fulfilled its responsibilities effectively during 2025/26 whilst identifying clear opportunities to further enhance assurance integration, reporting quality and strategic oversight as part of the Health Board's wider governance improvement journey. The proposed transition to an Audit, Risk and Assurance Committee reflects this evolving role and the Committee's continued focus on strengthening assurance to the Board.

The Committee is asked to:

- **NOTE** the summary of business considered in private session to be reported in public.
- **NOTE** the outcome of the Committee Self-Assessment 2025/26.
- **APPROVE** submission of the revised Terms of Reference to the Board, noting the proposed change of name to the Audit, Risk and Assurance Committee.
- **APPROVE** the Committee Annual Report 2025/26 for submission to the Board.
- **APPROVE** the Committee Cycle of Business 2026/27.
- **NOTE** progress against the Corporate Governance Improvement Plan

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data

Not applicable for this report

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

IHC	Integrated Healthcare Community

CORPORATE GOVERNANCE REPORT

1. Y SEFYLLFA SITUATION

- 1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 Y CEFNDIR BACKGROUND

- 3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

4 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

4.1 Summary of Business Considered in Private

- 4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
- 4.1.2 The below items were considered in private at the meeting held on 19.5.26
 - AC26.57 Financial Annual Accounts 2025/26
 - AC26.58 Draft Annual Accountability Report 2025/26
 - AC26.59 Counter Fraud Functional Standard Return
 - AC26.60 Head of Internal Audit Opinion
 - AC26.61 External Audit Progress Update
 - AC26.62 Response to Audit Enquiries Letter
- 4.1.3 The Cycle of Business at Appendix A sets out the Committee's scheduled business to ensure a structured, timely, and transparent approach to decision-making and oversight.

4.2 Committee Annual Assessment and Annual report

The Committee has undertaken its annual self-assessment for 2025/26, the findings of which are set out at Appendix B. The assessment indicates that the Committee is professional, stable and well-run, with strong confidence in the contribution of Internal Audit and Counter Fraud. It also recognises clear strengths in the Committee's governance structure, including clear Terms of Reference, annual review arrangements, effective chairing, strong secretariat support, constructive debate and a supportive meeting environment.

The self-assessment also identifies areas where the Committee can further strengthen its effectiveness as it moves into the next stage of maturity. These relate principally to improving assurance clarity, strengthening integration with other Committees, improving understanding and use of the Board Assurance Framework, achieving greater consistency in report quality, and increasing awareness of relevant regulatory and inspection matters. These areas are not presented as fundamental weaknesses in the Committee's operation, but as opportunities to strengthen strategic oversight, reduce uncertainty and improve the consistency of assurance provided to the Board.

The Committee's draft Annual Report for 2025/26, attached at Appendix C, summarises the business undertaken between 1 April 2025 and 31 March 2026 and highlights the areas the Committee intends to consider further over the next 12 months. The report confirms that the Committee's annual Business Cycle was a key component in ensuring that the Committee effectively discharged its role during the year, and that the Committee has played a key role in the development and monitoring of the Health Board's governance and assurance framework.

During 2025/26, the Committee fulfilled its work plan across a broad range of areas including the Financial Annual Accounts, Annual Report, Head of Internal Audit Opinion, ISA 260 Audit of Financial Statements, Counter Fraud reporting, audit recommendation tracking, policies and written control documents, Welsh Health Circulars and Ministerial Directions, declarations of interest, corporate risks and the Board Assurance Framework, the Scheme of Delegation, Standing Orders, conformance reporting, Structured Assessment and internal and external audit progress reports.

The Annual Report identifies a number of achievements during the year, including the transition of Committee Chair, continued Executive Director reporting on outstanding audit recommendations, improved monitoring of internal and external audit recommendations, strengthened reporting on assigned corporate risks, updates to the Governance and Accountability Framework, improvements to the Corporate Risk Register and Board Assurance Framework, enhanced policy management arrangements, strengthened visibility of Internal Audit, improved monitoring of Ministerial Directions and Welsh Health Circulars, introduction of the Corporate

Governance Improvement Plan, and oversight of the Commissioning Assurance Framework.

Taken together, the self-assessment and Annual Report provide assurance that the Committee has discharged its core responsibilities effectively during 2025/26. They also demonstrate a clear commitment to continuous improvement, with the next phase of development focused on strengthening assurance integration, improving the consistency and quality of reporting, enhancing regulatory awareness, reducing repetition, ensuring clearer closure of items, and using the structured business cycle to support sharper strategic oversight.

The Committee is therefore asked to note the outcome of the self-assessment and approve the Annual Report for submission to the Board, recognising both the assurance provided in respect of the Committee's work during 2025/26 and the improvement areas identified for 2026/27. The proposed change of Committee name to Audit, Risk and Assurance Committee will further support the Committee's evolving role in providing strategic assurance across governance, risk management, internal control and assurance arrangements.

4.3 **Committee Terms of Reference**

4.3.1 The Committee is requested to consider a change of name to more accurately reflect the purpose of the Committee and the business considered as BCUHB's Audit, Risk and Assurance Committee as provided at Appendix D.

4.4 **Corporate Governance Improvement Plan**

Progress continues to be made against the Corporate Governance Improvement Plan, with particular focus during the quarter on strengthening standards of business conduct, improving organisational governance arrangements and enhancing the quality of assurance provided to the Board and its Committees. This work remains aligned to the Board Assurance Framework objective of building an effective and accountable organisation and supports delivery of the Health Board's wider governance improvement agenda.

A significant area of focus has been the continued development of arrangements to support high standards of business conduct across the Health Board. This work has been informed by the recent Internal Audit review, which recognised positive progress in a number of areas whilst identifying opportunities to further strengthen governance awareness, accountability and consistency of practice across the organisation. Whilst the overall direction of travel is positive, it is recognised that further work is required to ensure governance expectations and standards of business conduct are fully embedded at all levels of the organisation.

During the reporting period, the Board approved the revised Policy Framework in July 2026. Attention will now turn to implementation of the framework, which is intended to support a more consistent and robust approach to the development, review, approval and management of policies across the Health Board. This represents an important step in strengthening governance arrangements, supporting compliance and ensuring greater organisational consistency.

Progress has also been made in developing an Operational Governance Framework. The framework is intended to provide greater clarity regarding governance structures, operational accountabilities, escalation processes and decision-making responsibilities across the organisation. Following completion of the initial development phase, engagement will now be undertaken with senior leaders to seek feedback and ensure that the framework is practical, proportionate and aligned to operational requirements ahead of wider implementation.

Alongside this work, a Decision-Making Framework has been developed and will be considered by the Executive Committee during Quarter 3. The framework is intended to support greater clarity regarding delegated authority and decision-making responsibilities and will form an important component of the Health Board's wider governance architecture.

The forthcoming independent Well-Led Review represents a further significant milestone in the Health Board's governance improvement journey. The review provides an opportunity to obtain independent assessment of the effectiveness and maturity of leadership and governance arrangements and to identify areas where further improvement may be required. Given the relevance of the review to the Committee's responsibilities, regular updates will be provided to enable Audit Committee to seek assurance regarding progress, emerging findings and delivery of associated improvement actions.

Recognising the important role of Audit Committee in providing assurance to the Board regarding the effectiveness of governance, risk management and internal control arrangements, work is also being progressed with the Chair, Committee Chairs and Executive Leads to strengthen the consistency and quality of assurance reporting across the Board's committee structure. Particular focus is being given to the continued development and application of the Alert, Assurance and Advice (AAA) reporting methodology. This work aims to strengthen the quality of assurance available to the Board by ensuring that risks, levels of assurance, matters requiring escalation and key decisions are reported in a more consistent and transparent manner across all Committees.

Priorities for Quarter 3 will include implementation of the Policy Framework, engagement and finalisation of the Operational Governance Framework,

consideration of the Decision-Making Framework by Executive Committee, commencement of the Well-Led Review and continued work to improve the consistency of AAA reporting and assurance flows between Committees and the Board. These actions will support the continued strengthening of effective systems of governance and remain key components of the Corporate Governance Improvement Plan.

5 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

5.1 There are no matters for escalation.

6 ARGYMHELLION RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor
The Committee is asked to:

- **NOTE** the summary of business considered in private session to be reported in public.
- **NOTE** the outcome of the Committee Self-Assessment 2025/26.
- **APPROVE** submission of the revised Terms of Reference to the Board, noting the proposed change of name to the Audit, Risk and Assurance Committee.
- **APPROVE** the Committee Annual Report 2025/26 for submission to the Board.
- **APPROVE** the Committee Cycle of Business 2026/27.
- **NOTE** progress against the Corporate Governance Improvement Plan

ASESIAD / ASSESSMENT

Cyswilt â'r Blaenoriaethau
Strategol
Link to Strategic Priorities



1. Building an effective organisation

Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:
If more than one applies, please list below:

Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF24-01 Building an Effective and Accountable Organisation

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
<u>Answydd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answydd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Answydd Enablers of Quality All Apply	Meysydd Answydd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll? Counter Fraud Impact Assessment Have you considered the counter fraud impacts	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report

Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.



Betsi Cadwaladr University Health Board

Audit Committee

Cycle of Business
(1 April 2026 – 31 March 2027)

Betsi Cadwaladr University Health Board should, on an annual basis, receive a cycle of business that identifies the items which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Committee Cycle of Business covers the period 1 April 2026 to 31 March 2027.

The Committee Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a “Non-Routine Board Business (Forward Work Plan)” for ‘one-off’ Ad-hoc items raised during the course of meetings.

The role of the Audit Committee is set out in the Terms of Reference which is available here: [Insert here]

Committee Chair Paul Lambert	Independent Members Rhian Watcyn Jones Dyfed Jones	Executive Members Russell Caldicott (Executive Director of Finance) Pam Wenger (Director Corporate Governance)	In Attendance Danielle Timmins (Head of Local Counter Fraud) Clara Day (Head Responsible for Clinical Audit) Dave Harries (Head of Internal Audit) Andrew Doughton (Representative of Auditor General – External Audit)
Committee Vice Chair Urtha Felda			

AUDIT COMMITTEE CYCLE OF BUSINESS 2026-27

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			21 April 2026	19 May 2026 (Private)	23 June 2026	July 2026	18 Aug 2026	Sep 2026	20 Oct 2026	Nov 2026	15 Dec 2026	Jan 2027	16 Feb 2027	Mar 2027	April 2027	May 2027
Preliminary Matters																
Welcome and apologies for absence	Director of Corporate Governance	All Regular Meetings	R	R	R		R		R		R		R		R	R
Declarations of Interest	Director of Corporate Governance	All Regular Meetings	R	R	R		R		R		R		R		R	R
Minutes of the previous Meeting	Director of Corporate Governance	All Regular Meetings	R		R		R		R		R		R		R	
Action Log	Director of Corporate Governance	All Regular Meetings	R		R		R		R		R		R		R	
Governance, Risk & Assurance																
Update on Outstanding Audit Recommendations	Executive Directors to present on a rolling basis	All Regular Meetings	R				R		R		R		R		R	
Corporate Risk Register Report	Director of Corporate Governance	Quarterly					R		R				R		R	
Board Assurance Framework Report	Director of Corporate Governance	Bi-Annually					R						R			
Corporate Governance Report: - Summary of Business to be reported from Private - Forward Workplan - Detail of Breaches of Standing Orders - Committee Cycle of Business* - Committee Terms of Reference* - Committee Annual Report* - Committee Self-Assessment* (Going forward those documents marked with an * will go to the Committee in April)	Director of Corporate Governance	All Regular Meetings	R				R		R		R		R		R	

[illegible]

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			21 April 2026	19 May 2026 (Private)	23 June 2026	July 2026	18 Aug 2026	Sep 2026	20 Oct 2026	Nov 2026	15 Dec 2026	Jan 2027	16 Feb 2027	Mar 2027	April 2027	May 2027
External Audit Plan 2026/27	Audit Wales	Annually	R													
Structured Assessment	Audit Wales	Annually	R								R					
Specific External Audit Reports as required	Executives invited to attend as required	As Required	R		R		R		R		R		R		R	
Counter Fraud																
Local Counter Fraud Service Progress Report	Executive Director of Finance	All Regular Meetings	R				R		R		R		R		R	
Local Counter Fraud Service Workplan 2025/26	Executive Director of Finance	Annually	R													
Financial Annual Accounts and Annual Report																
Financial Annual Accounts 25/26	Executive Director of Finance	Annually	Verbal update in private	R	R											R
Financial year end key judgements	Executive Director of Finance	Annually	R private													R
Annual Accountability Report 2025/26	Director of Corporate Governance	Annually	Draft in private	R	R											R
Counter Fraud Functional Standard Return	Executive Director of Finance	Annually		R												R
Head of Internal Audit Opinion and Annual Report	Head of Internal Audit	Annually	Verbal update in private	R	R											R
ISA 260 Audit of Financial Statements (include Enquiries of those charged with Governance)	Audit Wales	Annually			R											
External Audit Progress update	Audit Wales	Annually		R												R
Response to Audit Enquiries Letter	Director of Corporate Governance	Annually		R												R
Local Counter Fraud Annual Report	Executive Director of Finance	Annually			R											
Procurement Annual Report	Executive Director of Finance	Annually					R									
Closing Business																
Agree Items for Referral to Board / Other Committees	Chair		R	R			R		R		R		R		R	R
Review of meeting effectiveness	Chair	All Regular Meetings	R	R			R		R		R		R		R	R

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			21 April 2026	19 May 2026 (Private)	23 June 2026	July 2026	18 Aug 2026	Sep 2026	20 Oct 2026	Nov 2026	15 Dec 2026	Jan 2027	16 Feb 2027	Mar 2027	April 2027	May 2027
Date of the next meeting	Chair	All Regular Meetings	⌚	⌚	⌚		⌚		⌚		⌚		⌚		⌚	⌚
Resolution to exclude the Press and Public	Chair	All Regular Meetings	⌚				⌚		⌚		⌚		⌚		⌚	
Private Agenda																
Local Counter Fraud Service Progress Report (Private)	Executive Director of Finance	All Regular Meetings	⌚				⌚		⌚		⌚		⌚		⌚	



**Trugaredd
Compassion**



**Agored
Openness**



**Parch
Respect**

AUDIT COMMITTEE SELF ASSESSMENT

2025-2026 Results Summary



**Trugaredd
Compassion**

Audit Committee Self Assessment 2025-26

Overall Assessment

Committee is **professional, stable, and well-run**

Strong confidence in **Internal Audit** and **Counter Fraud**

Key gaps: **assurance clarity, report consistency, regulatory awareness**

Operationally strong → Strategically uneven



**Agored
Openness**



**Parch
Respect**

What's Working Well



**Trugaredd
Compassion**

Governance & Structure

Clear Terms of Reference

Annual review

Effective chairing

Strong Secretariat support



**Agored
Openness**

Audit & Counter Fraud

High trust in Internal Audit

Progress reports valued



**Parch
Respect**

Culture & Dynamics

Professional behaviour

Constructive debate

Supportive environment

Key Weaknesses



**Trugaredd
Compassion**

Weaknesses & Risks

Assurance System Uncertainty

Integration with other committees unclear

Board Assurance Framework not fully understood

Mixed confidence in assurance robustness

Legislative/regulatory compliance unclear



**Agored
Openness**

Report Quality Variability

Some papers strong, others **patchy**

Executive support inconsistent

Impacts assurance depth



**Parch
Respect**



**Trugaredd
Compassion**

Areas of Low Familiarity

Non-statutory audit work

Regulatory inspections

Management refusal of audit recommendations

External quality reviews



**Agored
Openness**

Message:

High “Don’t know” responses → **low exposure, not poor performance**



**Parch
Respect**

Opportunities for improvement



**Trugaredd
Compassion**

Assurance Integration

Clarify committee inter-dependencies
Improve visibility of risk flows



**Agored
Openness**

Report Quality

Clear templates
Pre-submission checks



**Parch
Respect**

Regulatory Awareness

Horizon-scanning updates
Targeted briefings

Meeting Flow

Reduce repetition
Clear closure of items
Structured business cycle

Conclusion



**Trugaredd
Compassion**

Committee is **highly effective in core duties**
Strong professional relationships



**Agored
Openness**

Next-stage maturity requires:

Better assurance integration
More consistent reporting
Stronger regulatory awareness



**Parch
Respect**

Enhancements will **strengthen strategic oversight** and reduce uncertainty

AUDIT COMMITTEE

Annual Report 2025-26

FOREWORD

I am pleased to present the 2025-26 Annual Report of the BCUHB Audit Committee which outlines the activity for the period 1 April 2025 – 31 March 2026.

Sir Paul Lambert
Chair of the Audit Committee

AUDIT COMMITTEE Annual Report 2025 - 2026

1. Introduction

- 1.1 This report summarises the key areas of business activity undertaken by the Committee between 1 April 2025 and 31 March 2026 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.
- 1.2 The Committee's Annual 'Business Cycle' was a key component in ensuring that the Committee effectively carried out its role during 2025 – 26.
- 1.3 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the (activity/function).

2. Role and Responsibilities

- 2.1 The primary purpose of the Committee is to act on behalf of the Board to:
 - 2.1.1 Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales.
 - 2.1.2 Independently monitor, review and report to the Board on the processes of governance, and where appropriate, facilitate and support, through its independence, the attainment of effective processes.
 - 2.1.3 Where appropriate, advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.
 - 2.1.4 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.
 - 2.1.5 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.
 - 2.1.6 Work with all Committees of the Board to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.
 - 2.1.7 Receive assurance on delivery against relevant Planning Objectives aligned to the Committee in accordance with Board approved timescales, as set out in BCUHB's Annual Plan.

3. Agenda Planning Process

- 3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.
- 3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.
- 3.3 The secretariat for the meeting was provided by Laura Jones and latterly by Diane Davies.

- 3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

- 4.1 The Board approved the Terms of Reference, as endorsed by the Committee on 4.3.25, at the Board meeting held on 29.5.25, subsequently there were no amendments considered necessary in year in respect of the Terms of Reference and Operating arrangements for the Audit Committee.
- 4.2 The new Committee Cycle of Business for the Audit Committee is being presented for approval on 18 August 2026, however the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues. The Committee will be renamed to Audit, Risk and Assurance Committee.

5. Membership, Frequency and Attendance

- 5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.
- 5.2 During the year the Committee met on six occasions in public session, with member attendance as follows:

Name	Audit Committee Attendance
Paul Lambert (Committee Chair from October 2026)	Three out of three
Urtha Felda	Six out of six
Rhian Watcyn Jones	Five out of six
Dyfed Jones	Five out of six
Karen Balmer (Committee Chair to July 2026)	Two out of two

- 5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

- 6.1 The Committee fulfilled its work plan for 2025-2026 covering a wide range of activity. This work can be summarised under the following headings;
- a) Financial Annual Accounts 2025/26
 - b) Annual Report 2025/26
 - c) Head of Internal Audit Opinion and Annual Report 2025/26
 - d) ISA 260 Audit of Financial Statements
 - e) Local Counter Fraud Annual Report and Counter Fraud Functional Standard Return 2025/26
 - f) Progress against Outstanding Audit Recommendations
 - g) Update on Internal and External Audit Recommendations
 - h) Health Board Policies and Written Control Documents
 - i) Welsh Health Circulars and Ministerial Directions
 - j) Declarations of Interest and Gifts and Hospitality
 - k) Corporate Risks and Board Assurance Framework associated with the Committee
 - l) Scheme of Delegation
 - m) Standing Orders Reservations and Delegation of Powers
 - n) Conformance Report

- o) External Audit Progress Report
- p) Internal Audit Progress Report
- q) Structured Assessment
- r) Local Counter Fraud Progress Report

7. Key Achievements/Benefits:

7.1 As a reader you will see from this report what a successful and varied year the Audit Committee has had during 2025-26. Although detailed more fully above and within the Committee papers, some of the key highlights were:

- Successful transition of Committee Chair with full engagement from members and supporting officers.
- Continued cycle of Executive Directors reporting on outstanding audit recommendations with improvements made to monitoring Internal and External recommendations through the Executive Team and extended to include reporting on assigned corporate risks.
- Supported the implementation of the Accountability Statement process from 2026 onward, noting that the Audit Committee would provide oversight as part of the Health Board's overall governance and accountability mechanisms.
- Received updates to the Health Board's Governance and Accountability Framework, including revisions to the Scheme of Reservation and Delegation (SORD).
- Continued improvements to the content and format of the Corporate Risk Register and Board Assurance Framework
- Monitored the implementation of a more robust policy management process and ensured risk assessment of overdue policies was undertaken and escalation process introduced.
- Strengthened the profile of Internal Audit and its function and benefits within the organisation.
- Improved processes to monitor implementation of Ministerial Directions and Welsh Health Circulars.
- Strengthened the regular Statutory Compliance report through amalgamation of various reports including audit tracking and policy compliance. As well as balancing the level of detail needed to provide confidence of effective assurance levels.
- Introduced reporting of a Corporate Governance Improvement Plan.
- Monitored the implementation of a Commissioning Assurance Framework to strengthen governance.
- Assurance was provided that improvements to processes had been implemented to ensure robust Clinical Audit plans were in place and being monitored effectively.
- Assurance was provided that a Learning Repository had been installed for lessons learned along with the introduction of thematic learning reviews across the Health Board.
- Continuous evaluation of meeting effectiveness was undertaken at each meeting including input from internal and external attendees.
- Development sessions were held to focus on Committee improvements, Risk Management and the Role of Internal Audit and Executive support.
- Covered a wide range of governance and assurance activities including:
 - Financial accounts and audit reports.
 - Risk management and control frameworks.
 - Policy and compliance oversight.
 - Fraud prevention
- Conducted a self-assessment using the Audit Committee Handbook.
- Regular 'AAA Reports' were submitted to the Board.
- Transparent publication of minutes and papers on the Health Board's website.

8. Key Challenges

- 8.1 A focus for the Committee in 2026 forward into 2027, will be the work which is underway to give assurance at a strategic level.
- 8.2 Finally, although these challenges remain, the Committee will continue to monitor activity and develop innovative ways to support new developments and opportunities.

9. Committee Effectiveness & Performance

- 9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.
- 9.2 A Committee effectiveness questionnaire will be issued again circa February 2027, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

9. Reporting the Committee's Work

- 9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.
- 9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Conclusion and way forward

- 10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.
- 10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.
- 10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
[Committees and Advisory Groups - Betsi Cadwaladr University Health Board](#)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

AUDIT, RISK and ASSURANCE COMMITTEE

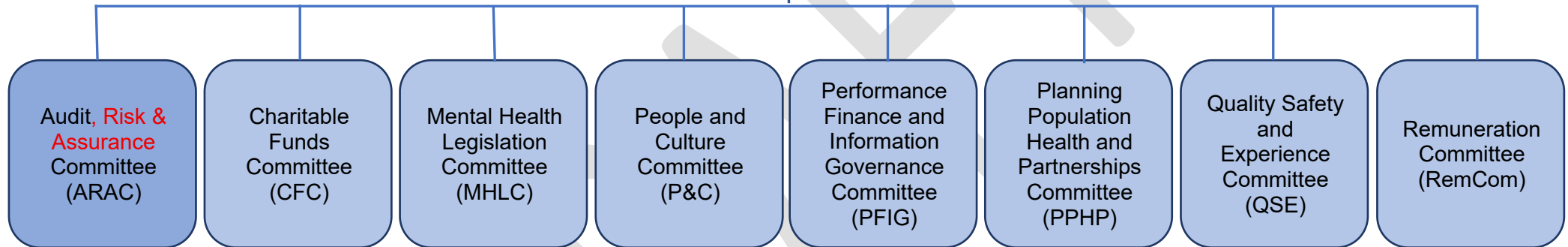
Terms of Reference & Operating Arrangements
(Schedule 3.5 of the Standing Orders)

Date approved by Health Board:

Betsi Cadwaladr University Health Board

Advisory Groups

Healthcare Professionals Forum (HPF)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)



Version Control

Version	Issued to	Date	Comments
V0.1	Audit Committee	04.03.25	Endorsed for approval at the May Board
V1.0	Board	29.05.25	Approved
V1.01	Audit Committee	18.08.26	Seek endorsement for submission to the Board

TERMS OF REFERENCE

1 INTRODUCTION

- 1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that “The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board’s behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board’s commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees
- 1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit, Risk and Assurance Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2 PURPOSE

2.1 The purpose of the Committee is to act on behalf of the Board to:

- 2.1.1 Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the Health Board’s system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board’s objectives, in accordance with the standards of good governance determined for the NHS in Wales.
- 2.1.2 Independently monitor, review and report to the Board on the processes of governance, and where appropriate, facilitate and support, through its independence, the attainment of effective processes.
- 2.1.3 Where appropriate, advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.
- 2.1.4 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation’s activities, both clinical and non-clinical.
- 2.1.5 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.
- 2.1.6 Work with all Committees of the Board to ensure that governance and risks are part of an embedded assurance framework that is ‘fit for purpose’.
- 2.1.7 Receive assurance on delivery against relevant Planning Objectives aligned to the Committee in accordance with Board approved timescales, as set out in BCUHB’s Annual Plan.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Audit, **Risk and Assurance** Committee will comment specifically upon:

3.1 Governance, Risk Management and Internal Control

3.1.1 The Committee shall review the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives and designed to support the public disclosure statements that flow from the assurance processes, including the Accountability Reports.

This includes:

- the organisation's ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government, the NHS Wales Executive and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;
- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens.

3.1.2 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, together with any accompanying Head of Internal Audit documents and opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.1.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.1.4 This will be evidenced through the Committee's use of an effective assurance

framework to guide its work and that of the audit and assurance functions that report to it.

- 3.1.5 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.
- 3.1.6 The Committee will monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.
- 3.1.7 The Committee will also seek assurance on delivery against Integrated Medium Term Plan Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.
- 3.1.8 The Committee will consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework (BAF).
- 3.1.9 The Committee will be responsible for reviewing the Health Board's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.
- 3.1.10 The Committee will receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the Health Board and report to the Board the adequacy of these arrangements.
- 3.1.11 It will also review and report to the Board annually the arrangements for declaring, registering, and handling interests.
- 3.1.12 The Committee will approve the writing-off of losses or the making of special payments within delegated limits.
- 3.1.13 The Committee will also receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.
- 3.1.14 The Committee will receive a report on all Single Tender Actions and extensions of contracts.

3.2 Internal Audit

- 3.2.1 The Committee shall ensure that there is an effective internal audit (including of the capital / PFI function) established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.
- 3.2.2 This will be achieved by:

- reviewing and approving the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- reviewing the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;
- regular consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit safety;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- an annual review of the effectiveness of internal audit.

3.3 External Audit

3.3.1 The Committee shall review the work and findings of the External Auditor and consider the implications of, and management's responses to, its work. This will be achieved by:

- discussion and agreement with the External Auditor, before the audit commences, on the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
- discussion with the External Auditor on its local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
- reviewing all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
- reviewing progress against the recommendations of the annual Structured Assessment.

3.4 Other Assurance Functions

3.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

3.4.2 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies is brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

3.4.3 The Audit, **Risk and Assurance** Committee and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit, **Risk and Assurance** Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and

improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

- 3.4.4 The Audit, **Risk and Assurance** Committee will also seek assurances where a significant activity is shared with another organisation(s), in particular the NHS Wales Shared Services Partnership, Welsh Health Specialised Services Committee, Emergency Ambulance Services Committee and other regional committees. The Audit, **Risk and Assurance** Committee will expect to receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls.

3.5 Management

- 3.5.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- 3.5.2 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.
- 3.5.3 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.
- 3.5.4 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:
- the ISA 260 report to those charged with governance;
 - changes in, and compliance with, accounting policies and practices;
 - unadjusted mis-statements in the financial statements;
 - major judgemental areas;
 - significant adjustments resulting from the audit;
 - other financial considerations include review of the Schedule of Losses and Compensation; and
 - the Management Letter of Representation to the External Auditors.
- 3.5.5 The Audit, **Risk and Assurance** Committee shall prepare an Annual Report to the Board, timed to support the preparation of the Annual Governance Statement. The report should include, as a minimum, specific statements confirming that:
- the draft Annual Governance Statement is consistent with the view of the Committee on the organisation's system of internal control and that it supports the Board's approval of the Statement, subject to any reasonable limitations that the Committee wishes to draw to the attention of the Board;
 - the system of risk management in the organisation is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks;
 - the Committee has reviewed the system of assurance, and believes that it is fit for purpose;
 - there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been adequately resolved; and

- the current self-assessment by the organisation against the relevant risk management standards is consistent with the Committee's understanding, gained through its assurance work.

3.5.6 The Committee shall also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.5.7 The Committee should also ensure the provision of an effective Counter Fraud service that meets the standards set for the provision of Counter Fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee.

3.5.8 The Committee should assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)
NB: At least one of the two Independent Members should be a member of the Quality, Safety & Experience Committee

The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Finance (Executive Lead)

Director of Corporate Governance
Other Attendees
Other Executive Directors as required by the Chair
Other Senior Managers as required by the Chair
Head of Internal Audit
Head / Individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of Auditor General (External Audit)

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

7 COMMITTEE MEETINGS

7.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

7.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.
- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.3 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.
- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Finance at least six weeks before the meeting date.
- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

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8 REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

- 8.1 The Committee Chair, supported by the Committee Secretary, shall:
- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
 - Bring to the Board's specific attention any significant matter under consideration by the Committee; and
 - Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.
- 8.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

- 9.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.
- 9.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:
- Joint planning and co-ordination of Board and Committee business and
 - Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 9.3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.
- 9.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

- 12.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with all Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 12.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

PROGRAMME PLAN REPORT

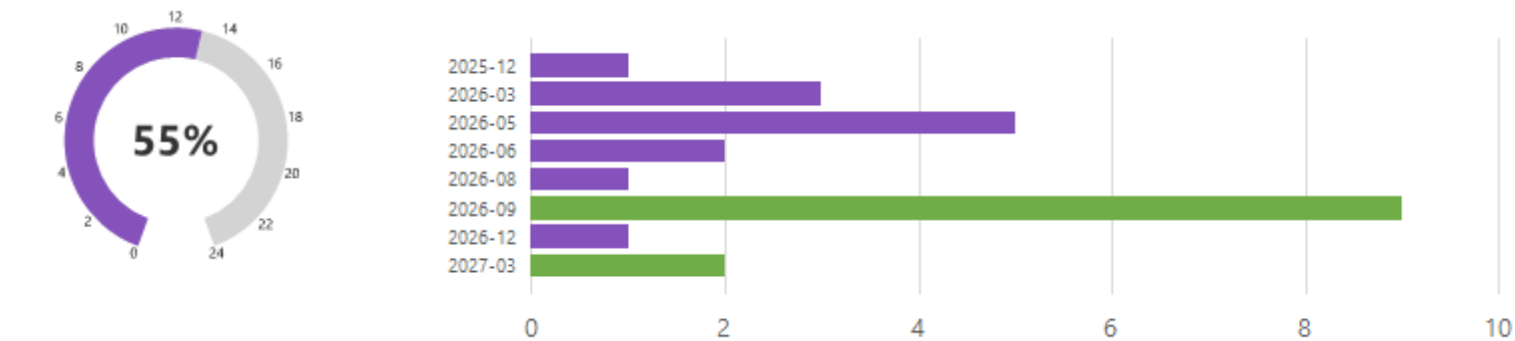


PROGRAMME TITLE: Effective Systems of Governance

Lead: Philippa Peake-Jones (BCUHB - Corporate Office)

SRO: Pam Wenger (BCUHB - Corporate Office)

11/08/26
16:34



Task Owner	Complete	In Progress	Total
Carol Shillabeer (BCUHB - Corporate Office)	1	0	1
Catrin Rhys Williams (BCUHB - Corporate Office)	0	1	1
Ffion Johnstone (BCUHB - Corporate Office)	0	1	1
Glesni Driver (BCUHB - Corporate Office)	1	2	3
Jody Evans (BCUHB - Corporate Office)	0	1	1
Pam Wenger (BCUHB - Corporate Office)	2	4	6
Phil Meakin (BCUHB - Governance & Communications)	1	0	1
Philippa Peake-Jones (BCUHB - Corporate Office)	5	2	7
Russell Caldicott (BCUHB - Corporate Office)	3	0	3
Total	13	11	24

Workstream	Title	Assigned to	Status	Priority	Due Date	% Complete
Compliance (Reporting, Systems, Processes and Policy Framework)	Streamline and strengthen the reporting arrangements for Internal and External Audit Recommendations (Structured Assessment)	Glesni Driver (BCUHB - Corporate Office)	Complete	Medium	29/06/26	100%
	The Health Board should increase the pace of its process to update high-risk policies (Structured Assessment Recommendation 2025)	Glesni Driver (BCUHB - Corporate Office)	In Progress	High	23/09/26	25%
	The Health Board should ensure that the Board receives Joint Commissioning Committee minutes and related assurance reports to enable it to discuss risks and implications of national commissioning arrangements (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	Medium	27/05/26	100%
	To simplify the Policy Management System and ensure improvements are made in terms of the reduction of overdue policies (Structured Assessment)	Glesni Driver (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	60%

Governance	◆	Continue to review and refine the business planning arrangements for Committees ensuring they are fit for purpose (Structured Assessment)	Pam Wenger (BCUHB - Corporate Office)	In Progress	High	29/09/26	0%
	◆	To continue to evolve the Executive Committee arrangements by formalising the 'sub' groups and ensure that they are operating effectively (Structured Assessment)	Catrin Rhys Williams (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	80%
	◆	Private Items at Board and Committee (Structured Assessment 2025)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	High	27/05/26	100%
	◆	The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports) (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	High	27/05/26	100%
	◆	Review the Operational Governance Framework as part of any changes to the 'operating model' as part of Foundations for the Future Programme (Foundations for the Future / Internal Audit Report)	Phil Meakin (BCUHB - Governance & Communications)	Complete	Medium	31/08/26	100%
	◆	To reflect on the Quality Governance reporting taking into consideration the recommendations from the Quality Governance Review by Audit Wales (Audit Wales)	Pam Wenger (BCUHB - Corporate Office)	Complete	Medium	29/06/26	100%
	◆	The Health Board should ensure that it has the appropriate programme management and governance arrangements in place to support the roll out of the Foundations for the Future Programme. (Structured Assessment)	Ffion Johnstone (BCUHB - Corporate Office)	In Progress	High	23/09/26	80%
	◆	Through regular review of the Governance Framework; ensure that it is fit for purpose and is reviewed and refreshed as part of an annual review and as part of the Foundations for Future Programme (Board Assessment)	Pam Wenger (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	80%
	◆	Review induction process for all Board Members (Board Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	50%
	◆	To continue to improvement meeting efficiency of the Board and Committees through the improvements in the paper quality through the introduction of refreshed standards for papers (Structured Assessment:)	Pam Wenger (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	0%
	◆	Improve the focus of Board formal and informal meetings to ensure the balance of the time spent by the Board on strategic discussions (Board Assessment)	Pam Wenger (BCUHB - Corporate Office)	In Progress	Medium	30/03/27	50%
	◆	AAA Reports Publication within 14 days of the (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	High	27/05/26	100%
	◆	Undertake and Annual Board Self Assessment	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	Medium	30/05/26	100%
Procurement and Contracting	◆	To ensure that all Corporate Directors attend procurement training and understand their roles (Internal Audit)	Carol Shillabeer (BCUHB - Corporate Office)	Complete	Medium	31/12/25	100%

	◆ To reduce the number of Direct Awards through the introduction of robust systems of monitoring and escalation (Internal Audit)	Russell Caldicott (BCUHB - Corporate Office)	Complete	Medium	30/03/26	100%
	◆ 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. (Internal Audit)	Russell Caldicott (BCUHB - Corporate Office)	Complete	Medium	30/03/26	100%
Risk Management	◆ Further embed risk management systems to ensure that risk is actively managed and demonstrable improvements in risk reduction are visible through the Corporate Risk Register (Internal Audit Reports / Structured Assessment)	Jody Evans (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	65%
Standards of Business Conduct	◆ Ensure all Directors and monitoring arrangements are in place for ensuring staff at Band C and above are completing their declarations of gifts and hospitality, including where such gifts and hospitality are declined (in accordance with the Standards of Business Conduct Policy) (Internal Audit Report)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	Medium	30/03/27	76%
	◆ A series of guidance documents be circulated to all Board Members and Budget Holders in respect of key conduct matters such as declarations of interest and gifts and hospitality (Internal Audit Report)	Pam Wenger (BCUHB - Corporate Office)	Complete	Medium	31/12/26	100%
	◆ Review the Standing Financial Instructions to take into account the requirements of the Procurement Act 2023 and introduce a Procurement Guide for all Staff (Internal Audit Report)	Russell Caldicott (BCUHB - Corporate Office)	Complete	Medium	30/03/26	100%



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Audit Committee

ADRODDIAD CYDYMFFURFIAETH AC SICRWYDD INTEGREDIG INTEGRATED COMPLIANCE AND ASSURANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Draft Status - Final Version will be Published
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Glesni Driver, Head of Statutory Compliance and Inquiries
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol Executive Summary

This report provides the Audit Committee with a comprehensive, assurance-focused overview of the Health Board's statutory compliance position. It brings together information relating to audit recommendations, regulatory oversight, policy compliance, national directives, and statutory inquiries to support the Committee's assessment of the **effectiveness of governance, risk management and internal control**.

The overall assurance position continues to be assessed as limited. This reflects a number of ongoing governance and compliance challenges, particularly within audit recommendation management and policy compliance. While important risks remain, progress is evident across several areas, including audit closure activity, regulatory improvement planning, policy review activity and strengthened oversight arrangements. Continued focus is required to ensure that improvements are delivered consistently and supported by robust evidence of implementation and impact.

The management of Internal Audit and Audit Wales recommendations remains an important area of focus. Whilst a number of recommendations remain overdue, including some that are more than six months old, work is ongoing to strengthen implementation, oversight and evidence submission processes. Progress continues to be made, although further improvement is required to ensure actions can be validated and formally closed in a timely manner.

Policy compliance continues to be an area requiring improvement. Whilst progress has been made in reviewing and updating policies, a backlog of overdue policies (53) remains and continues to limit assurance that governance documentation is fully current, aligned with statutory and regulatory requirements, and consistently implemented across the organisation. Particular focus is being placed on those policies with patient safety implications. Further work is required to reduce the backlog and strengthen confidence in the effectiveness of the Health Board's policy framework.

External regulatory activity continues to provide important assurance and scrutiny across a range of safety, quality and governance domains. Healthcare Inspectorate Wales activity remains significant, whilst Public Services Ombudsman for Wales recommendations and upheld complaints continue to require organisational attention and learning. Although compliance performance remains broadly positive, the nature and volume of regulatory activity highlights the need for continued focus on delivering sustainable improvements and addressing underlying system pressures.

The Health Board continues to respond to Ministerial Directions, Welsh Health Circulars and emerging national inquiry outputs through established governance and oversight arrangements. Progress is being made in implementing and monitoring these requirements, although the evolving external landscape will require ongoing oversight, coordination and assurance to ensure compliance and organisational learning are maintained.

Overall conclusion for Audit Committee:

The Health Board continues to work within a complex and evolving compliance and regulatory environment. While progress is evident across a number of areas, including audit closure activity, policy review, regulatory improvement planning and oversight of national requirements, opportunities remain to strengthen:

- the pace and consistency of delivery
- the quality and timeliness of supporting evidence
- clarity of ownership and accountability
- the effectiveness of assurance and oversight arrangements

Continued focus on these areas will support further improvement in the overall assurance position and reduce exposure to compliance and regulatory risks over time.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	15/07/2026	Agreed

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

HIW	Healthcare Inspectorate Wales
PSOW	Public Services Ombudsman Wales
CIW	Care Inspectorate Wales
RAG	Regulatory Assurance Group
IHC	Integrated Health Community
ECRS	Enhanced Community Residential Services
MDT	Multi-Disciplinary Team
EPOG	Executive Policy Oversight Group
WCDs	Written Control Documents
WHCs	Welsh Health Circulars
MDs	Ministerial Directions

ADRODDIAD CYDYMFFURFIAETH AC SICRWYDD INTEGREDIG INTEGRATED COMPLIANCE AND ASSURANCE REPORT

1 Y SEFYLLFA SITUATION

This report presents a consolidated view of statutory compliance activity and assurance across key governance domains. It is intended to support the Audit Committee in forming a view on whether the Health Board has effective arrangements in place to:

- identify and manage compliance risks
- implement and evidence audit recommendations
- maintain up-to-date and effective governance frameworks
- respond to regulatory scrutiny
- implement national requirements and inquiry learning.

Further detail on specific areas is set out in the following sections of the report.

2 Y CEFNDIR BACKGROUND

Statutory compliance requires the Health Board to operate within a complex framework of legislation, regulatory standards and national directives. This includes ensuring:

- effective systems of internal control
- compliance with audit and regulatory requirements
- robust policy and governance frameworks
- timely response to inspection findings and complaints
- implementation of Ministerial and national requirements.

Assurance is provided through audit, performance monitoring, regulatory engagement and governance processes. However, assurance is only effective where there is clear evidence that actions have been completed, validated and embedded in practice.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

The Audit Committee is asked to note that the overall statutory compliance assurance position remains limited. This reflects ongoing challenges within the audit and policy domains, alongside continued regulatory scrutiny and external assurance activity. Progress is being made across a number of areas; however, further work is required to strengthen assurance and provide greater confidence that governance and compliance arrangements are operating effectively.

The principal factors influencing the current position include the backlog of overdue audit recommendations, a number of overdue policies, ongoing Healthcare Inspectorate Wales and Public Services Ombudsman for Wales activity, and the continued development of oversight arrangements for Ministerial Directions, Welsh Health Circulars and inquiry-related learning.

3.1 Compliance Dashboard

Area	Status	Trend	Key Issue
Internal and External Audit	●	→	High number of overdue recommendations; delays in evidence submission
Policy Compliance	●	↑	Increasing overdue policies, including patient safety risks
Regulatory Activity (HIW/CIW)	□	→	Improvement plans progressing but some actions overdue
Ombudsman (PSOW)	□	↑	Increasing recommendations and sustained investigation levels
Ministerial Directions / Welsh Health Circulars	□	→	Progress made; oversight and tracking need strengthening
National Inquiries	□	→	Ongoing outputs require organisational readiness, and strengthened learning processes.

The overall compliance position remains under pressure, with progress evident in some areas but not yet sufficient to provide robust assurance.

3.2 **Audit (Primary Assurance Risk)**

Audit recommendations continue to influence the overall assurance position.

- Open recommendations remain across both Internal Audit and Audit Wales reviews
- Some recommendations remain overdue, including a number that exceed six months
- Improvement activity is underway to address outstanding actions and improve the timeliness of implementation and closure
- Assurance remains constrained in some areas where evidence required to validate completion and sustainability of actions is not yet available.

From an assurance perspective, the availability and quality of supporting evidence remains an important consideration in the closure process. Where evidence has not yet been provided or fully validated, it can be difficult to confirm that actions have been implemented effectively and that intended controls are operating consistently in practice. This may limit the level of assurance available and delay the formal closure of recommendations.

The closure process is therefore dependent not only on the completion of actions, but also on the ability to demonstrate that improvements have been embedded, are operating as intended and can be evidenced appropriately.

3.2.1 **Audit recommendations for Committee closure approval**

In line with the agreed process around the closure of audit recommendations, a number are now requiring Audit Committee final approval for closure.

A total of 29 audit recommendations are put forward for closure to the Audit Committee - 22 Internal Audit and 7 External audit recommendations - with a summary of each included in Appendix 1.

A copy of all open Internal Audit Unsatisfactory assurance audit recommendations is included in Appendix 2, and all open Limited audit recommendations in Appendix 3.

A copy of all open Audit Wales recommendations are included in Appendix 4.

3.2.2 Actions being progressed to improve compliance

- Ongoing work to address the backlog of Internal Audit and Audit Wales recommendations
- Actions are being progressed to close overdue recommendations and strengthen the timeliness of implementation
- Focus on obtaining and validating supporting evidence to enable formal closure of recommendations
- Submission of audit recommendations to Audit Committee for final closure approval.

3.3 Policy Compliance (Deteriorating Assurance Position)

The progress around policy compliance is not yet providing full assurance that governance arrangements are operating effectively.

Key issues include:

- 53 policies have now passed their review date, compared to 29 reported previously. This reflects both newly overdue policies and the existing backlog
- 24 overdue policies have patient safety implications
- 8 policies have been reviewed and updated since the previous reporting period, including 4 relating to patient safety
- Further work is required to improve the timeliness of policy review and approval processes and reduce the overall backlog.

While governance arrangements are in place, the current backlog of policies requiring review limits the level of assurance available regarding the currency and consistency of the Health Board's policy framework. Continued progress in reducing the backlog will strengthen confidence that policies remain aligned to legislative requirements, best practice and organisational expectations.

3.3.1 All-Wales or externally approved policies

A number of policies are subject to All-Wales or external approval arrangements and therefore the timing of review and publication is not wholly within the control of the Health Board. To support assurance, Executive Leads will be required to confirm that policies published more than three years ago remain extant and that any associated risks are being actively managed pending formal review or approval.

3.3.2 Actions being progressed to improve compliance

- ongoing work across portfolios to reduce the number of overdue policies
- eight policies have been updated since the previous reporting period, including four relating to patient safety
- continued oversight of overdue policies through governance processes
- introduction of executive sign-off for policies progressing through All-Wales or external approval routes to confirm they remain extant pending formal review or approval.

3.4 Regulatory Activity (Sustained External Scrutiny)

3.4.1 Health Inspectorate Wales

- action plans remain active, with some overdue actions
- multiple recent assurance requests highlight concerns in safety, staffing and quality
- inspection activity shows strong progress in some areas, but uneven completion overall.

3.4.2 Care Inspectorate Wales

- Position remains stable, with no immediate concerns.

3.4.3 Public Services Ombudsman for Wales

- 52 active cases
- increasing recommendations and upheld complaints
- continued high investigation levels.

Although compliance performance remains strong, the trend of increasing activity and findings indicates:

- sustained external scrutiny
- ongoing service and governance challenges
- need for continued focus on complaint handling and learning.

3.4.4 **Actions being progressed to improve compliance**

- Active management of Health Inspectorate Wales improvement plans, including progression of actions arising from inspections and assurance reviews
- Ongoing monitoring of recommendations arising from Ombudsman investigations and complaints
- Continued focus on organisational learning from regulatory findings and complaint investigations.

3.5 **National Directives**

The Health Board continues to oversee compliance with Ministerial Directions and Welsh Health Circulars, which represent an important element of the external regulatory framework and require ongoing assurance activity to evidence implementation, monitoring and adherence to national expectations.

3.5.1 **Ministerial Directions**

A total of 31 Ministerial Directions were received between 1 April 2025 and 31 March 2026.

- A total of 6 were for information only, and no action required
- A total of 20 required action, 13 of these have been actioned, with 2 partially completed
- Work is continuing on a further 5 to ascertain what if any action is required.

3.5.2 **Welsh Health Circulars**

A total of 48 Welsh Health Circulars were received between 1 April 2025 and 31 March 2026.

- A total of 4 were for information only
- A total of 1 was for Compliance, Action and Information, and has been actioned
- 37 were for action, with 20 of these completed, 4 partially completed, with work ongoing on the remaining 13
- Work is continuing on a further 6 to ascertain what if any action is required.

3.5.3 Actions being progressed to improve compliance

- All Ministerial Directions and Welsh Health Circulars have been disseminated to relevant leads
- Corporate Governance Team continues to undertake regular follow-up requests for progress updates
- Action required by Ministerial Directions is being monitored, with completed actions evidenced and remaining requirements progressing through implementation
- Welsh Health Circular actions continue to be tracked, with completed, partially completed and outstanding actions subject to ongoing oversight.

3.6 National Inquiries

National inquiries, including the UK Covid-19 Inquiry, will continue to shape the external assurance and compliance landscape, with potential implications for governance, resilience, workforce and service delivery arrangements. The Health Board is developing its readiness to respond to emerging recommendations and embed organisational learning, supported through established governance and oversight arrangements. Continued coordination will be important to ensure that inquiry-related requirements are implemented alongside existing compliance priorities.

3.6.1 Actions being progressed

- Preparatory work continues to ensure organisational readiness for recommendations and learning arising from national inquiries, including the UK Covid-19 Inquiry
- Oversight arrangements are in place to identify implications for governance, resilience, workforce and operational models
- Strengthened process around identifying and embedding learning from these inquiries.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

No matters are identified for escalation at this time. The issues highlighted within this report are already subject to existing governance, oversight and assurance arrangements. Audit Committee will continue to monitor progress through future compliance and assurance reporting.

5 ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

- **NODI/NOTE** the contents of this report and the current statutory compliance assurance position
- **CYTUNO/AGREE** the closure of the audit recommendations listed in Appendix 1.

ASESIAD / ASSESSMENT		
Cyswilt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    	
	4. Improving quality, outcomes and experience	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not applicable, other than those relating to individual regulatory body reviews and audit reports	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Data to Knowledge Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Meysydd Ansawdd Domains of Quality All Apply Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☒ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☐ No impact



Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



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Betsi Cadwaladr
University Health Board

APPENDIX ONE – SUMMARY OF AUDIT RECOMMENDATIONS FOR COMMITTEE CLOSURE APPROVAL

APPENDIX TWO – INTERNAL AUDIT OPEN UNSATISFACTORY ASSURANCE AUDIT RECOMMENDATIONS

APPENDIX THREE – INTERNAL AUDIT OPEN LIMITED ASSURANCE AUDIT RECOMMENDATIONS

APPENDIX FOUR – AUDIT WALES OPEN AUDIT RECOMMENDATIONS



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INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS FOR AUDIT COMMITTEE CLOSURE APPROVAL

No.	ID	Audit body	Report title	Last update received / summary narrative
CHIEF DIGITAL AND INFORMATION OFFICER				
1	0528	Internal Audit	Digital Operating Model	The MIO job description formally establishes the role as a senior clinical digital leader, with clear responsibility for leading and championing DDAT strategy, driving paper-to-digital transformation, influencing clinical culture and behaviours, supporting and challenging clinicians, piloting new technologies in practice, and providing system-wide clinical leadership to enable safe adoption of digital ways of working and sustained cultural change.
2	1482	Internal Audit	Network and Disaster Recovery	ICT Environmental and Physical Security Standard documented
3	1487			

DIRECTOR OF PARTNERSHIPS, ENGAGEMENT AND COMMUNICATIONS				
1	1558	Internal Audit	Partnerships, Engagement and Communication	Submitting a consolidated evidence pack to support closure of the outstanding items. This includes: • PEC Internal Audit closure mapping sheet (mapping each agreed action to evidence of implementation) • PEC Assurance Framework (Interim), setting out the structured approach to delivery, monitoring and assurance • PEC Progress and escalation log, providing a record of oversight, risks, decisions and escalation • Supporting PEC Delivery Plan (by quarter)
2	1561			Since the original audit, we have strengthened our approach to assurance through: • A consolidated delivery plan with defined benefits and evidence requirements • Quarterly monitoring and peer review of all actions • Clear ownership of evidence at service level, with structured oversight • Introduction of a formalised progress and escalation log to capture key decisions and risks A retrospective summary of oversight for 2025 has also been included, with enhanced formalisation of processes from late 2025 onwards. Taken together, these arrangements provide a consistent and proportionate framework which meets the intent of the agreed actions

EXECUTIVE DIRECTOR OF PUBLIC HEALTH

1	1666	Internal Audit	Public Health – Grant funded activity	The Public Health Team (Populations Health Service) request the development plans from the at risk services referred to from the Audit. WOD have been made aware of the risks associated with non recurrent funding for any staff within the services

DIRECTOR OF CORPORATE GOVERNANCE

1	1456	Audit Wales	Structured Assessment 2024	Board visit areas have now been agreed, with a supporting protocol approved by the Board and visits are already underway. The remaining visits will be scheduled and delivered over the next 12 months.
2	1573	Internal Audit	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	Governance Hub in place, and regularly updated
3	1706	Internal Audit	Learning – Regulatory Reporting	A procedure has been developed and approved by the Executive Policy Oversight Group, and published on BetsiNet.
4	1796	Audit Wales	Structured Assessment 2025	The Health Board new report template in use, with link to template on the Corporate Governance Hub
5	1797	Audit Wales		The AAA Reports are included within 10 working days of committees
6	1799	Audit Wales		The Board receives JCC minutes and related assurance reports, as per the Board agenda
7	1800	Audit Wales		The Directors' Accountability Statement were issued on 16/04/2026, with a response date of 30/04/2027.
8	1806	Audit Wales		

EXECUTIVE DIRECTOR OF FINANCE; DIRECTOR OF CORPORATE GOVERNANCE

1	1755	Internal Audit	Contract management and procurement review – Corporate Directors	NWSSP have been notified of the update SORD and SFIs. In terms of contracts – reports taken to the Board. See supporting evidence

DIRECTOR OF ENVIRONMENT AND ESTATES

1	1342	Internal Audit	Corporate Legislative Compliance - Fire Safety	Fire Risk Assessments presented to the Fire Safety Group meetings.
2	1345			
3	1346			
4	1347			
5	1348			
6	1608	Internal Audit	Waste Management - 2025	Information contained on the 'Environment and Waste Management' BetsiNet page.

EXECUTIVE DIRECTOR OF FINANCE

1	1399	Internal Audit	Charitable Funds - 2024	Been through all internal governance, waiting for it to be approved and Charity Commission side to be completed. All been reviewed and approved by a legal professional. Went to Board in May 2026 as part of Corporate Governance report.
2	1415	Internal Audit		All fundraising activity is included in the CFC 'Team Update' document created by the Head of Fundraising, this is reported to the CFC quarterly.
3	1467	Audit Wales	Review of Cost Savings Arrangements	The 25/26 Annual plan set out a recurring savings target of £30m, with a stretch of £40m being allocated to the IHCs. Total delivery of savings in 25/26 is £56.9m. The final full year effect of recurrent savings is £32.7m so whilst individual IHCs did not achieve the local stretch targets, the HB as a whole achieved the financial plan target.
4	1497	Internal Audit	Establishment Control	The Establishment control written control document was updated in 2025 and is live on BetsiNet. This is supported with additional materials on the EC pages in relation to the enhanced controls that are currently in place.
5	1498	Internal Audit		The quarterly reconciliation is no longer needed as you can no longer recruit
6	1655	Internal Audit	Orthopaedic Surgical Hub Llandudno Hospital - 2025	Equipment costs have been reviewed and updated and presented to Board.
7	1760	Internal Audit	Value and Sustainability – Delivering Quality Improvements	The guidance has been updated, adopted and circulated. This reaffirms the deadlines, and now incorporates the ability to keep transactional detail regarding savings in a specialist system where this might avoid unnecessary duplication.
8	1761			The guidance has been updated, adopted and circulated to incorporate the advice from WG.

OPEN 'UNSATISFACTORY' AUDIT RECOMMENDATIONS

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implement ation date	Latest update
0457	Operating Model	2024	Unsatisfactory	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	2. The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.	2. As part of the organisational structure review, all accountability frameworks will be reviewed	Carol Shillabeer, Chief Executive	30/06/2024	As part of the organisational structure review, an Operating Model supporting document/framework is being developed. This will be reviewed by the FFTF Programme Team. This is currently planned for review in May 2026 FFTF Board and will reflect feedback that is currently been gathered. The May FFFTF Board will consider the date for reporting to Executive Committee for approval
1431	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.1 Medical Resourcing Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025	Allocate "nuts & bolts" training programme has now commenced across Betsi, with one session a month offered over each site, with 1-2-1 training also continuing if needed.
1432	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.2 Medical Resourcing Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of silo expertise.	2.2 Establish clear communication channels for escalating job planning concerns or discrepancies.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025	Allocate "nuts & bolts" training programme has now commenced across Betsi, with one session a month offered over each site, with 1-2-1 training also continuing if needed.
1435	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.1 Business Continuity The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.	4.1 The system is web based so accessible anywhere and backup by Allocate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024	Work with the Business Continuity Team to develop a contingency plan for the EJob Plan system has begun. Progress has been slower than anticipated due to other operational priorities that required immediate attention.
1436	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.2 Business Continuity The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.	4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024	Work with the Business Continuity Team to develop a contingency plan for the EJob Plan system has begun. Progress has been slower than anticipated due to other operational priorities that required immediate attention.

1437	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.3 Business Continuity The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.	4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024	Work with the Business Continuity Team to develop a contingency plan for the EJob Plan system has begun. Progress has been slower than anticipated due to other operational priorities that required immediate attention.
1551	Waiting List Initiative payments – IHC Centre	2025	Unsatisfactory	High	Objective 1: There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales.	1. Health Board Procedure The Health Board has no Procedure detailing the planning, authorising, recording and monitoring of Waiting List Initiative (WLI) work in relation to medical and dental staff. We have noted Cardiff and Vale University Health Board have published a dedicated procedure that could be used as a template for developing one in the Health Board (Reference: Waiting List Initiative Procedure - Medical & Dental Staff UHB 515).	1. The Health Board develop, in partnership, and ratify a Waiting List Initiative Procedure to ensure Waiting List Initiative sessions are applied consistently and subject to effective scrutiny and approval across the Health Board, eliminating any inconsistent practice that may be in place with localised, undocumented procedures. The Central IHC, on behalf of the Chief Operating Officer, will lead the development of a BCUHB Waiting List Initiative Procedure	Tehmeena Ajmal, Chief Operating Officer	31/07/2025	No progress update received
1570	Effective Governance - Cancer Services	2025	Unsatisfactory	High	Objective 3: The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	3. Clinical Audit Management advised that due to absence of Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. A gap is identified and will therefore be reviewed by the SLT during 25/26.	3. Level 3 audits within radiotherapy are in their infancy and this is a piece of work that we are addressing following the HIW visit. We have asked an SAS Dr to support the mortality reviews with the Clinical Lead for Radiotherapy which addresses in part level 2 audits. Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer. Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity. The clinical Leads will focus on creating roles with Clinical Audit responsibilities within Consultant Job Plans as we continue to recruit into vacancies on a	Tehmeena Ajmal, Chief Operating Officer	31/03/2026	Ongoing job planning and substantive interviews for permanet Consultant Oncologists scheduled for May.
1672	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 4: Completed job plans reconcile to system records and session payments are correct	8. Regular review of payments to agreed job plan commitments (<i>finding in original audit report</i>) We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan. We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual reviewor simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan. FOLLOW-UP AUDIT REPORT FINDING: The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025 but have not corroborated this or requested sight of the draft dashboard.	8 REVISED ACTION IN FOLLOW-UP REPORT: Allocate is now linked to ESR to ensure sessions agreed reflect payment. An SOP to ensure implemented will be linked to policy and will be in place by December 2025.	Clara Day, Executive Medical Director	31/12/2025	We are currently awaiting final sign-off for the Medical & Dental ESR Pay Report SOP at the MWG meeting on 15 April. Training on "How to Use the Report" is already included in the training programme being delivered by the Job Planning Team as part of the ongoing rollout.

1673	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance	10. Medical and Dental Job Plan reporting (<i>finding in original audit report</i>) There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance. FOLLOW-UP AUDIT REPORT FINDING: The OMD Job Planning team send out a monthly Job Planning Compliance email that includes a link for the job planning dashboard to a pre-determined circulation. We are unclear whether this circulation captures all relevant leads with responsibility/accountability for job plan compliance. We contacted the seven clinical service Directors to obtain details of their People and Culture meeting or to confirm where job plan performance and assurance was discussed. We received a reply for Centre, East and West IHCs and Women's Services but received no reply from Mental Health and Learning Disabilities, North Wales Managed Clinical Services or Cancer Services. We noted limited assurance reporting at a local level within IHC West on job planning. The West IHC Medical Director (Chair of the MWG) provided evidence of follow-up compliance with job plan completion to West operational leads. Women's Services hold monthly Centre, East and West	10 REVISED ACTION IN FOLLOW-UP REPORT: Monthly compliance figures are circulated to operational teams and the divisional and IHC medical leaders. It is tracked at Medical Workforce Group at Health Board Level. A compliance escalation and dissemination pathway will be in presented for sign off at November's Medical Workforce Group to ensure clarity on information sharing and scrutiny. An assurance mechanism will be in place by the end of Quarter 4 Real time data is accessible via Allocate. How to access will form part of the Allocate 'how to' training.	Clara Day, Executive Medical Director	31/03/2026	The OMD Job Planning Team issues a monthly Job Planning Compliance email, which includes a link to the job planning dashboard . This distribution list captures all relevant leads with responsibility and accountability for job plan compliance.

OPEN 'LIMITED' AUDIT RECOMMENDATIONS

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implement ation date	Latest update
0491	Health and Safety - 2024	2024	Limited	Medium	Matter Arising 3: Health & Safety Training (Operation)	3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: “the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007”.	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	Stuart Keen, Director of Environment and Estates	01/09/2024	Proposal put forward for Executive Team to fund and attend NEBOSH HSE Certificate in Health and Safety Leadership Excellence, 1-day course. Awaiting outcome. Quote provided Sept 2025 but expired 31/03/2026. The price for the delivery on site in North Wales would be £9,800. This is for up to a maximum of 15 delegates. New quote to be requested and then SK to present to Exec for approval.
0493	Health and Safety - 2024	2024	Limited	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	Stuart Keen, Director of Environment and Estates	30/04/2024	In April 2025 the Health Board transitioned to the NHS Employer Health and Safety Standards. These were implemented in two cyles (April and October). The findings/results from this new approach were presented to the People and Culture Committee in June 2025 and December 2025. This approach along with a revised Quarterly Health and Safety Performance Report that provides a pan-BCUHB and Divisional/Directorate picture, is contributing to the gap anlaysis and consideration is being given on how this is weaved into the Strategic Occupational Health and Safety Group.
1341	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety Policy.	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Stuart Keen, Director of Environment and Estates	20/03/2025	Policy presented at SOHSG in Feb 2026, comments received from IHC - East Director and adjustment made. EQIA being developed and once approved the Policy will be published on BetsiNet
1343	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM o5-03 Part A.	Stuart Keen, Director of Environment and Estates	20/03/2025	WHTM 05-03 Part A - Training will be issued during May / June 2026 and a review of training delivery will be undertaken by Sept 2026.
1445	Consultant Job Planning	2024	Limited	Medium	Objective 4: Completed job plans reconcile to system records and session payments are correct	9. Additional sessions undertaken outside of the substantive post We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive breach.	9. IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025	A review of all job plans has begun and the team will be working with operational and medical colleagues to ensure that all additional activity is appropriately declared, incorporated into job plans, and monitored going forward. This will include reinforcing the requirement for full disclosure of any additional sessions and ensuring that appropriate approval and recording processes are followed.
1534	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	1. Process Management	1.1: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1: The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider.	Russell Caldicott, Executive Director of Finance	30/06/2025	The draft CAF has now been presented at PFIG ad is due to be presented again at informal exec meeting on April 15th followed by submisison to May 2026 board for approval.
1535	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	2. Contractual Obligations	2.1: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1: The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings.	Russell Caldicott, Executive Director of Finance	30/06/2025	The draft CAF has now been presented at PFIG ad is due to be presented again at informal exec meeting on April 15th followed by submisison to May 2026 board for approval.
1536	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements.	Russell Caldicott, Executive Director of Finance	30/06/2025	The draft CAF has now been presented at PFIG ad is due to be presented again at informal exec meeting on April 15th followed by submisison to May 2026 board for approval.

1537	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.2: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	3.2: The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other ~~forum required~~ .	Russell Caldicott, Executive Director of Finance	30/06/2025	The draft CAF has now been presented at PFIG ad is due to be presented again at informal exec meeting on April 15th followed by submisison to May 2026 board for approval.
1538	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	4. Board Assurance	4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1: The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF.	Russell Caldicott, Executive Director of Finance	30/06/2025	This work is being undertaken as part of the whole review and will work in conjunction with 1537
1571	Effective Governance - Cancer Services	2025	Limited	High	Objective 4: Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as	4. Open / Overdue Incidents As of March 2025, the service has 195 open incidents, with 154 of these overdue.	4. The number of incidents since March has decreased significantly to 98. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner through discussions at the daily Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further monitoring through the monthly PSQG Meeting.	Tehmeena Ajmal, Chief Operating Officer	31/10/2026	The division have 49 open incidents. The divisional Governance facilitator has undertaken training and advice to support the clinical teams to review and close incidents
1575	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 2: Declare System (Operation)	2.1 (b) To introduce a monitoring process for declarations in accordance with the revised Standards of Business Conduct Policy approved by the Audit Committee in May 2025.	2.1 (b) Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025	All scheduled notices are set to go to emails - see attached screenshot of Declare system. When the new PADR form becomes live this will include the DOI reference
1578	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 4: Board Members declarations of interest (Operation)	SAME AS 2.1 (b) 4.1 (b) The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end. • Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise. • Ensures the public register of Board Member interests is maintained and kept up to date.	SAME AS 2.1 (b) 4.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025	All scheduled notices are set to go to emails - see attached screenshot of Declare system. When the new PADR form becomes live this will include the DOI reference
1580	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	SAME AS 2.1 (b) 5.1 (b) Management: • Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit	SAME AS 2.1 (b) 5.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025	All scheduled notices are set to go to emails - see attached screenshot of Declare system. When the new PADR form becomes live this will include the DOI reference
1581	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (a) To undertake specific improvement project looking at the processes at an IHC level in relation to Declaring Gifts and Hospitality . (March 2026)	6.1 (a) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.	Pam Wenger, Director of Corporate Governance	31/03/2026	We are working towards creating a Governance Network which will capture this work.

1582	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (b) To establish Governance Network working with operational leads to support the implementation of this work .	6.1 (b) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective monitoring per policy requirements.	Pam Wenger, Director of Corporate Governance	31/03/2026	We are working towards creating a Governance Network which will capture this work.
1622	Falls Management - Follow up	2025	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. Current status – Partially implemented Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was considered, the associated costs were deemed unaffordable and unsustainable. A text message reminder service was proposed to reduce the resources spent on employees who missed training sessions. However, it was determined that this option is not feasible	3.1(a) Action 2 - Training There is also a review underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring this training is accurate – Head of Health & Safety (29th August 2025).	Angela Wood, Executive Director of Nursing and Midwifery	29/08/2025	Work continues to progress. The review should be complete based on the responses returned, and will be passed onto the ESR team. Whilst it is hoped this review will resolve some compliance issues, it will also depend as to whether ESR can remove/add and further advice is needed in this regard once the data has been handed over.
1623	Falls Management - Follow up	2025	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. Current status – Partially implemented Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was considered, the associated costs were deemed unaffordable and unsustainable. A text message reminder service was proposed to reduce the resources spent on employees who missed training sessions. However, it was determined that this option is not feasible	3.1(a) Action 3 - Training Discussions ongoing regarding the upskilling of Manual Handling Champions to support the Corporate Team with local delivery of refresher training, thereby reducing the number of colleagues attending a classroom-based refresher – Head of Health, Safety & Security -October 2025.	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2025	Funding to progress upskill of champions requested via Betsi Cadwaladr - Education Commissioning Template to HEIW 27-28. Awaiting outcome.

1632	Performance Management Framework and Reporting	2025	Limited	High	Objective 1: There is a governance structure with mechanisms for regular monitoring and escalation in place.	1. Governance Through the review of the Executive Delivery Group Minutes and reports received from two IHCs and MHL D we have not been able to confirm that Decision and Action Logs from substructure or Integrated Performance Scorecards feed into the Integrated Performance Executive Delivery Group or that performance translates down to individual BAPPs.	1. The Integrated Performance Framework to be fully implemented during quarter 2 of 2025/26. This will entail monthly meetings with the larger management structures delivering patient care. The reporting hierarchy will ensure “ward to board” assurance reporting.	Russell Caldicott, Executive Director of Finance	30/09/2025	The new IPF was presented at HB on 26.03.2026 but requires some amendments based on comments received. Approval of the IPF has now been delegated to PFIG Committee on 28.04.2026 after which, the new IPF will supersede the previous version and be fully implemented from May 2026.
1633	Performance Management Framework and Reporting	2025	Limited	High	Objective 2: There is evidence to support reported performance data and narrative.	2. Performance We have been unable to verify the source and rationale underpinning the identification and reporting of local performance metrics that are included in addition to the national measures. Consequently, we are unclear that the highest risk local matters are being reported for scrutiny and assurance.	2. Local performance indicators and escalations are created where a services performance is showing early signs of distress or consistently failing a target. Whilst outside of the NHS Wales performance framework it is essential to identify areas that need further scrutiny and assurance as the NHS Wales performance framework cannot cover all delivery of the NHS. The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any	Russell Caldicott, Executive Director of Finance	30/09/2025	As part of the IPF, a new escalation and de-escalation model has been developed and will be implemented from June 2026. The model examines performance across a myriad of metrics and provides an objective and repeatable method for escalation via IPEDG in the first instance. The model will be shared with Executive colleagues in May 2026.
1634	Performance Management Framework and Reporting	2025	Limited	High	Objective 3: Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service user.	3. Performance Accountability Whilst we note executive accountability meetings take place and accountability/service performance reports produced; these are not operating consistently as expected. We were unable to confirm the outcomes of performance meetings as we did not receive any minutes/evidence of specific actions set to address the required improvement in performance.	3. Finding accepted. The Health Board is in the process of setting up monthly meetings with IHCs and pan BCU patient facing services. Initial meetings have been held in quarter 1 with monthly meeting to be diarised during quarter 2 to run monthly from September onwards.	Russell Caldicott, Executive Director of Finance	30/09/2025	Performance reviews of corporate services were held in November 2025 and the latest round is underway through April 2026. These reviews are chaired by the CEO. The Performance reviews for the operational/ clinical services have not been held as planned in 2025/26. this has been due to intense focus on planend care (including Cancer and Diagnostics) and urgent & emergency care recovery which involved weekly must attend meetingsand a high level of scrutiny, support and intervention. It was felt that to add for4mal monthly performance reviews on top of an already intensly poulated calendar would be counter-productive. However, for 2026/27 the formal, monthly performance accountability reviews will be held from June 2026 onwards.
1658	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	High	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these	3. Limited Plan Testing While some exercises have been conducted, most BCPs and incident plans have not been tested. Testing is not yet consistent across all departments. Women’s Services exercises are delayed, and exercises for Emergency Departments are still in planning.	1) To draft an options appraisal on how we can best achieve the above. 2)To receive Executive sponsor sign off on the options appraisal, and take though the governance route of CCAG, Executive Committee and PPHP if required. 3)To then action and implement the agreed recommendation/option following governance reviews.	Jane Moore, Executive Director of Public Health	31/12/2025	NEW EXPECTED COMPLETION DATE 30/06/26 1) EPRR are drafting a Business Case for additional 8a following paper approval from CCAG and Executive sponsor. 2) The Business Continuity Exercising programme which is now in use and is the updated. Note: The programme will not run at the pace
1660	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	Medium	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these	5. Outdated Policies and Procedures. Core EPRR policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.	All outstanding EPRR policies, templates, plans, policies and SOPs are agenda for approval/sign off at the next CCAG 30th September 2025.	Jane Moore, Executive Director of Public Health	31/12/2025	NEW EXPECTED COMPLETION DATE 30/04/26 1) Business continuity standard operating procedure has been reviewed, placed into correct template and fully updated. Being progressed through process.
1679	Digital Benefits and Change	2025	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.2 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.	2.2 Agree benefits reporting structure with the Executive Team to demonstrate the value of projects across various BCUHB governance groups outside of the DDaT Team.	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	31/03/2026	On the 26th November 2025 the Executive Committee agreed that DDaT would provide quarterly updates to the PPHP committee to demonstrate the value of projects. The first of these reports was due to be considered in March, but due to a scheduling error this will now be May 2026.

1680	Digital Benefits and Change	2025	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.3 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.	2.3 Review the Benefits Framework to include updated reporting and escalation routes.	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	31/03/2026	SBAR to DPDG 18/11/25 recommending a revision to Section 11 - Benefits Governance of the Benefits Management Framework, describing the Forums and Reporting structures that should be established at Owner, Project, Programme and Portfolio Level. Recommendation approved and Benefits Framework updated to reflect.
1702	Learning – Regulatory Reporting	2025	Limited	High	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.	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, 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.	• 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 • The Corporate Governance Directorate to work with areas/services to develop processes to manage regulatory reports and engagement independently.	Pam Wenger, Director of Corporate Governance	31/03/2027	There has been good progress on updating the Relationship Management Matrix with details around our regulators, statutory and professional bodies. This information will now be reviewed to ensure completeness of information, and confirm with the Executive Team Members that they are happy that their information has been captured.
1703	Learning – Regulatory Reporting	2025	Limited	High	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.	2.1 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	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	Pam Wenger, Director of Corporate Governance	31/03/2026	Work has been progressing to implement this Group, but this requires Executive Team member engagement and consultation to ensure that correct Group membership and reporting requirements. A meeting has been arranged between the Director of Corporate Governance and key Executives for 16/04/2026 to discuss. The future of the Regulatory Assurance Group will be discussed at this meeting.
1704	Learning – Regulatory Reporting	2025	Limited	High	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.	2.2 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	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. • To develop a corporate procedure and reporting routes for the monitoring of regulatory reports at a corporate level; eg, MHRA, HSE and other regulators	Pam Wenger, Director of Corporate Governance	31/03/2026	This policy/procedure will need to be developed once arrangements are in place to capture, report, monitor and escalate regulatory report requirements.
1705	Learning – Regulatory Reporting	2025	Limited	High	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.	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.	• 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.	Pam Wenger, Director of Corporate Governance	31/03/2027	The Statutory Compliance Reports has been expanded to include details of progress around some quality regulators, but will need to be expanded further as necessary.

1707	Learning – Regulatory Reporting	2025	Limited	High	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.	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.	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.	Pam Wenger, Director of Corporate Governance	31/03/2027	At present, the Relationship Management Matrix is captured on an Excel spreadsheet, which is appropriate in the initial stage to capture information, but will not be suitable as a long-term solution to record and monitor reports and information shared by these regulators. Discussions are ongoing around a Compliance Management System, which will follow the full lifecycle, from legislation, regulation, regulators, policies, audits and risk management. but these discussions are in the very early stages.
1749	Complaints management	2025	Limited	High	Objective 2: Complaints have followed the relevant process and are supported by documentation and evidence i.e. investigation reports, learning.	3. Learning and Improvement Plan action plans – Compliance with Policy 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	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. 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.	Angela Wood, Executive Director of Nursing and Midwifery	01/08/2026	From 1st April, Launch of LTP, all template letters have been revised to reflect legislative changes, including updated process maps and SoPS. Patient Experience Department transformational change has concluded to form a dedicated Patient Experience Service (PES) which will support the triangulation of learning from complaints and incidents.
1751	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	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 <u>one (8%) of thirteen had attended procurement training</u> .	• 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)	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31/12/2025	A procurement briefing session was provided at Board Development on 3rd December. An online Mandatory training module has also been aligned to Exec Position numbers with compliance currently around 50%. This will now be monitored and updated in line with Business as usual for mandatory training compliance.
1752	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	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 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.	• Ensure all Tier 1–2 officers sign Accountability Agreements for 2025/26. • Escalate non-compliance to Audit Committee with reasons for refusal	Russell Caldicott, Executive Director of Finance	31/12/2025	New Accountability Agreements are to be issued for 2026/27. Any agreements not signed will be reviewed and discussed with the individual to establish reasons for non-agreement.

1754	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board’s Standing Financial Instructions are complied with at all times.	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. Suppliers should be invited to bid via the Procurement Service appointed e-procurement solution”.	• 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)	Russell Caldicott, Executive Director of Finance	31/03/2026	Procurement training sessions for Directors and Budget Holders are to continue in 2026/27 with any new budget holders included. Additional Budget Holder training to be developed and issued, including the new All Wales training module developed by the NHS Wales Finance Academy.
1759	Value and Sustainability – Delivering Quality Improvements	2026	Limited	High	Objective 1: Robust process and governance arrangements are in place to manage and support implementation / delivery of the Value and Sustainability workstreams. All approved initiatives adhere to the principles of Value and Sustainability with a clear focus on improving quality and outcomes.	1. Value and Sustainability The Health Board Guidance for Savings 2025-26 provides comprehensive support for the finance and costs aspect of savings applications and reporting, however, does not reference non-financial, wider value and sustainability factors. Furthermore, there is no provision in the Savings Submission Document (SSD) to record or evaluate the impact of implementation on non-financial measures such as quality and outcomes. Whilst we recognise there is no formal national policy/guide outlining specific requirements regarding the inclusion and consideration of non-financial factors in the development, implementation, and reporting of Value and Sustainability saving plans, the principle that Value and Sustainability is broader than financial cost savings is outlined in the Health Board Integrated Medium-Term Plan 2025-28 2E.1 that states ‘Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement.’ We confirmed that work has commenced on developing the monitoring and reporting of Value and Sustainability schemes to provide oversight of delivery against a wide portfolio of benefits and quality measures. A draft Value Benefits Realisation framework has been developed which includes defined benefits, measurement methods,	1.0 Combine Clinical Variation & Value-Based Health Care into a merged workstream which will act as the primary driver for quality-led clinical improvement initiatives within the V&S framework. This newly formed workstream will be operational in Q4 (with priority areas of focus agreed by end Feb-26). 1.1 A comprehensive ‘Value’ benefits framework is already in development based on the HFMA value definition: Outcomes + Experience / Cost (developed in conjunction with BCU’s Benefits Lead). This will provide a more holistic (quality) view of programme delivery, over and above savings. The final version will be presented for ratification at Programme Board Feb-26. Any future initiatives will be prioritised against this wider framework. 1.2 Work has commenced with the PMO to refine and utilise the Portal as the vehicle to capture and report benefits realisation for ‘non-transactional’ value schemes that deliver against multiple metrics of value. This will sit alongside the existing national monitoring return, which focuses exclusively on cost savings. This will be completed by end of March-26 and be operational for delivery against our agreed programme of work for 26-27 1.3 Programme reporting (particularly highlight reports and reports into IPEDG and PFIG) will cover the wider set of value metrics included in the benefits framework. This will be in place for end of March-26 and will provide greater assurance around the quality outcomes of the V&S programme for 26-27.	Russell Caldicott, Executive Director of Finance	31/03/2026	1.0 Workstreams now combined inaugural meeting scheduled for 16/04, chaired by the Executive Medical Director, with extensive clinical input. 1.1 Benefits framework covering the wider determinants of value developed and to be reviewed by Programme Board in April-26. This will support the development of the schemes within workstreams 5&6 which are focussing more on efficiency, productivity, outcomes, experience and environmental value metrics 1.2 Work continues with senior PMO team to utilise Portal for capturing programme benefits. All funded projects for 26/27 to be uploaded and monitored via the Portal. 1.3 Highlight report amended and wider metrics to be reported once wider portfolio of projects agreed and operational (May-26)
1762	Estate Management – Estates and Facilities Alerts	2026	Limited	High	Objective 1: Governance & Oversight - to review the governance arrangements and internal processes for receiving, reviewing, and disseminating Estates and Facilities (E&F) Alerts within the Health Board.	1. Governance and Oversight of Estates and Facilities Alerts Operational Estates Alerts are received by the Head of Estates and Senior Estates Officer – Policy and Technical Compliance, however there is no evidence of consistent oversight or assurance that all alerts are reviewed and acted upon. Although a central register exists to record (E&F) Alerts, actions taken in response are not routinely updated or tracked to completion. There is currently no overarching governance group within Estates responsible for reviewing all safety alerts and ensuring compliance. There is no Standard Operating Procedure (SOP) for the management of (E&F) Alerts.	• Interim measure has been implemented with a SOP to include a single point of access to all alerts so all parties can access the information. This includes a monitoring spreadsheet. • Review the full directorate reporting structure and how that relates to the other groups within the organisation to ensure clarity and accountability. This is driven by other factors and will include additional roles to support responses such as this. • Define a directorate governance structure to encompass all statutory reporting and the management of Alerts and record such in a SOP. • Finalise a reporting route to ensure organisational assurance and the potential for an annual Estates compliance report.	Stuart Keen, Director of Environment and Estates	Interim measure: 28/02/2026 31/07/2026 for the finalisation of the structure given the wider organisation restructure and approval of governance.	Interim SOP developed and utilised.

1763	Estate Management – Estates and Facilities Alerts	2026	Limited	High	Objective 2: Monitoring and Reporting – to assess the adequacy, timeliness, and evidence of actions taken in response to E&F alerts, including risk assessments, implementation of required measures, and monitoring of compliance or closure.	2. Monitoring implementation A central register exists to record (E&F) Alerts, but follow-up actions are not consistently updated. A review of eight (25%) recent alerts showed that three out of the eight (37.5%) had no evidence of implementation, suggesting incomplete follow-up.	• The SOP will include the development of a tracker to include information such as: Description, Risk Rating, Owner, Target Implementation Date, Implementation Evidence, Link to Corporate Risk Register, etc. • As an interim measure, a tracker will be developed to collate the current Alerts and form the basis of a transition mitigation pending the SOP.	Stuart Keen, Director of Environment and Estates	Interim tracker – 28/02/2026 Full tracker – 31/07/2026	Register being updated following receipt of Hazard Alerts and shared with Estates leads within appropriate safety group.
1764	On-call arrangements	2026	Limited	High	Objective 1: Review the on-call arrangements across the Health Board, and consider whether rotas include the relevant mix/seniority of staff, are fair, and sustainable.	1. On-call rota composition, fairness and sustainability Although a draft on-call policy is now in place and provides improved clarity on the intended structure and seniority of Gold, Silver and Bronze rotas, the policy remains unapproved and not fully embedded. As a result, rota composition continues to rely on local practice. Staff feedback indicates ongoing perceptions of inequity in rota participation, lack of transparency regarding inclusion/exclusion of eligible staff, and concerns about the sustainability of rotas due to workload pressures, turnover and reliance on goodwill. These issues were also highlighted in the previous audit and remain partially unresolved.	1. Management will work with the Foundations of the Future workstreams and Workforce & OD to develop, consult on, and ratify an On-Call Rota Policy that establishes a fair, transparent and sustainable on-call model across Gold, Silver and Bronze rotas. The policy will clearly define the rota structure, eligibility criteria, and expected seniority, and will set out roles and responsibilities for all participants, including escalation and decision-making arrangements. The policy will explicitly state that all substantive and/or acting post-holders at Band 8a and above are expected to participate in the on-call rota unless exceptional circumstances apply, with the criteria and approval process for exemptions clearly documented to ensure consistency and transparency. Rota governance arrangements will be included, covering accountability for roster composition, maintenance, monitoring of participation, and periodic review to support sustainability and address workload pressures and turnover risks. Ownership and ongoing responsibility for the policy will sit with Operations, including ensuring the policy is embedded into business-as-usual processes and communicated to relevant staff. Until the Foundations of the Future arrangements are implemented and the policy is formally ratified, the Health Board accepts the residual risk associated with the absence of an approved and fully embedded on-call policy.	Tehmeena Ajmal, Chief Operating Officer	31/12/2026	Under the Civil Contingencies Act 2004 the Health Board is required to have appropriate on call rotas in place to support major incident /business continuity response. Changes to the organisational structure following FFtF will need to be taken into account in the future operating model to ensure that the on-call model is fit for purpose. Work is ongoing through WOD /FFtF to facilitate ALL Job Descriptions at 8a and above to be within the requirements to participate in the appropriate management on call rota (Bronze/Silver/Gold). Whilst no timescale is currently available this action is expected to bring additional resource onto all of the on-call management rotas which should reduce the frequency of on calls and improve resilience. 16 senior managers at 8C and above, in corporate roles, were contacted and asked to volunteer to participate in the Silver on call rota (with training, education and support provided). 3 colleagues agreed. 2 have commenced and 1 is undergoing further training and support. The rest declined and were supported by their Exec Director. As of 16.04.26 23 participate in the SoC rota (this will reduce in June following x2
1765	On-call arrangements	2026	Limited	High	Objective 2: Review whether staff are taking, or are able to take, compensatory rest periods following on-call duty, and how these are recorded/monitored.	2. Compensatory rest arrangements The audit found that relevant workforce policies covering compensatory rest are in place and have been updated, and management communications have reinforced expectations. However, staff feedback indicates that many on-call staff remain unable to take compensatory rest in practice due to workload and operational pressures. Where rest is taken, it is often informal and inconsistently recorded. There is no standardised process for recording, monitoring or reviewing compensatory rest following on-call duty, a weakness also identified in the previous audit.	2. Reiteration for the need to plan compensatory rest into staff diaries and work plans will be included within the EPRR/on call Preparing for Emergencies training undertaken by the EPRR Lead, which will be mandatory for all staff on the on-call rotas.	Tehmeena Ajmal, Chief Operating Officer	31/12/2026	Included within EPRR on-call training. Has been reiterated to staff via operational masterclass training sessions. Is included in the Draft on-call policy

1767	On-call arrangements	2026	Limited	Medium	Objective 4: Confirm that appropriate training, guidance, and support are available for staff	3. Training, guidance and support for on-call staff The audit found clear improvement since the previous review, with training specifically for major incidents available and supported by a central training matrix. Monthly Management On-Call Drop-In Sessions also aid learning. However, staff feedback indicates that awareness and experience of training, guidance and practical support is not yet consistent across all services. Access to site-specific guidance and formalised debriefing remains variable, and while training completion is monitored, there is limited evidence of routine review of ongoing competency and learning needs.	3. EPRR and on call training to be mandated for all staff on Bronze Silver and Gold rota – and to be updated every 3 years Where staff repeatedly fail to book or attend training, this is to be escalated through line management and, where appropriate, the relevant executive for resolution.	Tehmeena Ajmal, Chief Operating Officer	31/03/2027	Conversation to be held with ESR to make the training mandated and live on ESR. ~25 EPRR on call training sessions have been offered internally. 79.4% (154) undertaken this training this is an improving trend Monthly on-call learning sessions remain well attended with good discussion and support X2 Operational Masterclasses have been delivered with good attendance. Operational Advice and guidance for on-call has been developed and is held on the on- call information platform on Microsoft teams Training compliance reports are taken to CCAG quarterly. Monthly compliance training reports are shared with Directors to support attendance. Rolling training programme will continue. Escalation to line managers will continue in line with current training escalation framework
1768	On-call arrangements	2026	Limited	High	Objective 4: Confirm that appropriate training, guidance, and support are available for staff	4. As a Category 1 Responder, the Health Board supports Gold on call Executives to attend the pan-Wales ‘Exercise Wales Gold’ training to help maintain emergency response competencies, although attendance has only been tracked since 2025 and training places are limited. Currently only four Executives have attended the training. In the absence of all Executives having attended this training, the Health Board cannot demonstrate it has appropriate arrangements in place to evidence that staff have received the necessary training to respond effectively to emergencies, in line with the expectations of the Civil Contingencies Act and its statutory guidance.	4. Attendance at the Pan-Wales Gold training for all Gold on call to be mandated– and to be updated every 3 years Dates for 2026 Wales Gold Training circulated to all Gold on call (6 spaces available in 2026) – completed Head of EPRR to continue to seek additional training dates for the training programme with the national team.	Tehmeena Ajmal, Chief Operating Officer	31/03/2028	To date 6 (not 4) Gold on call have attended All Wales Gold training. 4 Gold are booked to attend All Wales Gold in 2026. 18 are on the GoC rora leaving 8 left to attend All Wales Gold Training. 4 Gold on call have not attended EPRR / on call internal training or All Wales Gold.
1769	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	Medium	Objective 1: To review the governance arrangements in place for managing NICE guidance across the Health Board in line with WG requirements, including implementation of Technology Appraisals.	1. Assurance to the Health Board The information provided to the Committee and Health Board through the Integrated Quality Reports is more limited than the detail shared with SCEG. This restricts the level of assurance available at Board level. There is an opportunity to strengthen reporting by placing greater emphasis on NICE guidelines, particularly those marked as partially achieved or not achieved, to ensure appropriate oversight and improvement monitoring.	A more detailed report will be provided for QSE to be included within the Integrated Quality Report. Strategic Clinical Effectiveness Group has already started to seek greater assurance on non-complaint and partially compliant guidance, and this will be reflected in reporting. The Teams first updated report will be provided for the bi monthly report, February to March into QSE in May 2026.	Clara Day, Executive Medical Director	27/04/2026	The timeline for this has not been reached yet within the internal audit, will be prepared for May's QSE report.
1770	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	High	Objective 1: To review the governance arrangements in place for managing NICE guidance across the Health Board in line with WG requirements, including implementation of Technology Appraisals.	2. New Treatment Fund / IPFR reporting The New Treatment Fund and Individual Patient Funding Requests (IPFR) paper has not been presented to the Executive Committee since February 2025. We note that reports were requested, prepared, and submitted to the committee for inclusion on the agenda.	Reports had been prepared throughout the year for Executive Committee but not presented. Pharmacy has now moved into the Office of the Medical Director who will ensure a regular reporting cycle. A report was presented to executive committee in Jan 2026. It has been agreed by the EMD that in future this will report via SCEG every 3 months with a corresponding update then to executive committee. It will focus not only on cost allocation but also whether we are meeting our duties to provide	Clara Day, Executive Medical Director	17/03/2026	First report to be discussed in SCEG 21/4 meeting copy attached as evidence in the email

1771	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	Medium	Objective 2: To determine how compliance with NICE guidance (including Technology Appraisals) is assessed and monitored, through tools such as clinical audits, patient surveys, and the NICE compliance database, with required reporting to the Welsh Government	3. Service compliance assessments An override function exists within the AMaT system, enabling either the Clinical Lead or the Clinical Effectiveness Team (CET) to bypass the completion of compliance reviews. Whilst it is acceptable for CET to exercise this functionality with appropriate justification, the absence of notification or rationale from the Clinical Lead when applying an override could result in ambiguity and weaken governance controls.	The problem with AMaT has previously been highlighted with the Welsh NICE Health Network (WNHN) by the health board. We have been informed that this will need to be an All Wales/England change, that all health boards will need to agree. Our latest update from AMaT 27/01/26, is as follows, AMaT confirmed that currently users can still override, though they are working on a change in Q1/2 that will prevent that in the future. The Clinical Effectiveness team will continue to keep on the agenda with them. We will develop a standardised message to send out to services explaining who can override and in which circumstances to strengthen controls.	Clara Day, Executive Medical Director	27/03/2026	This is currently being prepared and will be ready to send out by 1st May.
1772	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	High	Objective 2: To determine how compliance with NICE guidance (including Technology Appraisals) is assessed and monitored, through tools such as clinical audits, patient surveys, and the NICE compliance database, with required reporting to the Welsh Government	4. NICE Baseline Assessment Tools It was identified that NICE Baseline Assessment Tools (BATs) are not consistently completed following the recording of compliance assessments that are 'partially achieved improvement needed' or 'not achieved' via the AMaT system. We have been unable to obtain assurance that SMART action plans had been developed or that any associated follow-up actions were being effectively monitored and implemented.	Targeted training has already commenced by Clinical Effectiveness Team for BAT with clinical services and will continue until embedded (NICE guidance (NGs) and Clinical guidance (CGs) are the only ones requiring BATs). The Clinical Effectiveness team have recently trialled doing joint service reviews around the table for complex multiservice guidance. A recent success with the Mental Health Team and other related services. This will continue for complex guidance until BAT well embedded. Each time this is done services will be asked to have a BAT lead present, for future leadership within services completion. Teams training dates will be offered to services for basic BAT training with emphasis on appropriate action plans. The Clinical Effectiveness team will do quarterly audit checks on AMaT for compliance with BATs, appropriate action plans, and appropriate risk descriptions. The above will be monitored via SCEG reports for assurance.	Clara Day, Executive Medical Director	01/12/2026	Ongoing work being completed to ensure meets timeline implementation date
1787	Culture and Leadership Development – delivery of priorities	2026	Limited	High	Objective 3: The Health Board and relevant Committees are provided with sufficient information to be assured on the progress of delivery.	2. Assurance to Committee Although the People's Operations reports submitted to the People and Culture Committee include sections on Leadership and Development as well as Culture and Engagement, there is no indication that comprehensive progress updates on the Culture, Leadership, and Engagement plans are being provided to the Committee.	Quarterly reporting of the culture and leadership programme and access into leadership interventions to be implemented, linked to the action plan. Reporting on Integrated Leadership Development Framework to commence in March 2026, as part of the people operations pack, which is presented to People and Culture Committee. The establishment of the new People and Organisation Delivery group in Q1 26/27 will strengthen operational governance and provide oversight of programme delivery and relevant actions.	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31 March 2026 for compliance report. 30 June 2026 for Q1 review.	<i>New report - progress update to be provided for August Audit Committee</i>

1789	Risk Management and Board Assurance Framework - 2026	2026	Limited	High	Objective 2: The revision of the Corporate Risk Register and transfer of risks to the operational areas / Operational Leadership Team has been implemented effectively, ensuring no risks have been omitted, and the risks are being managed appropriately.	2. Overdue actions Operational Leadership Team (OLT) is overseeing a large risk portfolio aligned to the Chief Operating Officer (COO) and has recognised the need to review, close and escalate risks. There are 741 open risks across the Health Board overall, of which 287 open risks are assigned to the Chief Operating Officer as Executive Lead, and 12 open risks sit specifically under the Office of the COO. There are 219 overdue risks across the Health Board overall, of which 105 overdue risks have the COO as Executive Lead, and 11 overdue risks sit specifically under the Office of the COO (i.e., 11 of 12 risks in that grouping are overdue). This aligns with OLT's own recognition that the portfolio is large and contains risks that are several years old, requiring urgent review. Furthermore, across the three divisional risk registers tested (Workforce, Nursing and Mental Health), a significant proportion of risks have next review dates that are overdue, including higher-rated risks. • Workforce: 5 out of 16 risks are overdue for review • Nursing: 4 out of 17 risks are overdue for review • Mental Health: 0 risks overdue for review If risks are not reviewed on time, scoring, controls and actions may be out of date, and overdue reviews reduce confidence that risks are being actively managed. This can lead to unmanaged exposure and false assurance.	The Chief Operating Officer, supported by the Risk Management Team, will implement a focused recovery plan to address overdue operational risks. This will include: • a full review of all COO led risks to validate, update, close, or escalate them; • targeted prioritisation of higher-rated and older risks; and • the introduction of monthly monitoring and escalation of overdue reviews through OLT. This action will ensure risks are current, accurately scored, and actively managed.	Pam Wenger, Director of Corporate Governance	31/12/2026	A meeting has been scheduled with the Chief Operating Officer (COO) to agree an action-prioritisation plan to address overdue risks. In parallel, regular contact with risk handlers is ongoing through targeted email alerts and notifications via the Risk Leads channel to prompt timely reviews.
1792	Speaking Up Safely	2026	Limited	High	Objective 2: Staff are aware of the process for raising a concern, and can do so with confidence that they will be fully supported and not suffer detriment as a result.	2. Prolonged Case Durations & Limited Capture of Staff Feedback Speaking Up Safely case closure does not consistently demonstrate that concerns have been resolved to staff members' satisfaction. In the sample of 15 cases reviewed, 13 cases (87%) had no recorded staff feedback following closure, and seven cases (47%) exceeded the 28-day target for communicating outcomes. Average time to close cases as of 31 December 2025 was 65 days, significantly exceeding the national target of 28 days. The combination of prolonged case durations and limited capture of staff feedback reduces the organisation's ability to confirm effective resolution and embed organisational learning. While evidence of engagement and commitment to the Speaking Up Safely process was observed, overall assurance is reduced.	The actions below address prolonged Speaking Up Safely case durations and the limited capture of staff feedback, which reduce assurance that concerns are resolved effectively, within national timescales, and to the satisfaction of those raising them. 1. Agree and approve documented Speaking Up Safely case-closure criteria through the People & Culture Delivery Group. 2. Define resolution standards, clearly distinguishing substantive resolution from administrative closure. 3. Set minimum mandatory actions required prior to case closure, including documentation and decision sign-off. 4. Specify escalation triggers, including circumstances requiring extended timescales or senior review. 5. Embed mandatory staff feedback as a prerequisite to case closure. 6. Define escalation routes for cases exceeding the 28-day national target, with clear accountability. 7. Implement reporting to monitor case duration against the 28-day target. 8. Identify and escalate overdue or complex cases through routine performance reporting. 9. Undertake trend analysis of prolonged cases and recurring causes of delay to inform service improvement. 10. Provide regular assurance reporting to Executive Team via People and Culture Delivery group and relevant Committee. Collectively, these actions will strengthen assurance over timely case resolution, improve confirmation of effective outcomes, and support organisational learning while maintaining staff confidence in the Speaking Up Safely	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31/10/2026	<i>New report - progress update to be provided for August Audit Committee</i>

1793	Speaking Up Safely	2026	Limited	High	Objective 3: Designated contacts responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately.	3. Training The Health Board cannot demonstrate compliance with Speaking Up Safely training requirements. Training is not mandated, and there is no consistent monitoring or reporting of completion or refresher training for staff and managers. This position is not aligned with the Speaking Up Safely Framework for the NHS in Wales, which states an organisations requirement to ‘Ensure that appropriate training to deliver a Speaking Up Safely culture is rolled out to leaders, managers and staff throughout the organisation, as part of leadership and management development arrangements’. As a result, the Health Board cannot provide assurance that staff and managers—particularly those responsible for receiving and responding to concerns—have received appropriate and timely training.	The agreed actions below address the lack of Speaking Up Safely training and associated monitoring arrangements, which limits assurance that staff and managers are equipped to manage concerns effectively and increases the risk of misalignment with the Speaking Up Safely Framework for the NHS in Wales. 1. Develop and approve a workforce training framework setting out mandatory Speaking Up Safely and Duty of Candour training requirements for all staff involved in managing concerns. 2. Define target staff groups and roles, including minimum training standards and responsibilities. 3. Implement compliance monitoring, with routine reports showing training completion rates across staff groups. 4. Establish refresher training cycles to maintain ongoing competence and compliance. 5. Produce information to provide assurance on training uptake, compliance trends and gaps. 6. Embed Board/Delivery Group/Committee oversight through regular reporting and escalation where compliance falls below agreed thresholds. Implementation of these actions will provide improved assurance to the Board that Speaking Up Safely training arrangements are compliant with the NHS Wales framework and meet the effective management standard.	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31/12/2027	<i>New report - progress update to be provided for August Audit Committee</i>
1794	Speaking Up Safely	2026	Limited	High	Objective 4: Concerns raised by staff are monitored, reviewed and analysed to identify recurring themes or trends, with issues escalated as appropriate.	4. Lack of Documented Oversight of Speaking Up Safely by LPF and P&C Committee Although Speaking Up Safely is routinely included within the People Services and OD Overview Update Report to the LPF, there is no evidence of meaningful scrutiny or discussion by the LPF. The report to the People & Culture Committee does not include information on Speaking Up Safely. Reviews of meeting minutes and action logs across 2025 showed no recorded debate, challenge, or actions relating to Speaking Up Safely, despite both groups having explicit responsibilities for workforce governance, employee relations and whistleblowing assurance.	The agreed actions below are intended to address the lack of documented oversight and assurance of Speaking Up Safely at the Local Partnership Forum and the People & Culture Committee, and to strengthen governance arrangements in line with their workforce and whistleblowing responsibilities. 1. Embed Speaking Up Safely as a standing item at the Local Partnership Forum, with routine reporting and documented discussion. 2. Include Speaking Up Safely assurance as a standing section in the People Operations Report to the People & Culture Committee. 3. Ensure governance minutes and action logs evidence scrutiny, challenge and decisions relating to Speaking Up Safely. These actions directly address the absence of documented scrutiny and assurance, increasing visibility of staff concerns and strengthening confidence that emerging risks are identified, challenged and addressed through appropriate governance arrangements.	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31/08/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1795	Speaking Up Safely	2026	Limited	High	Objective 4: Concerns raised by staff are monitored, reviewed and analysed to identify recurring themes or trends, with issues escalated as appropriate.	5. Inability to Demonstrate Compliance with Public Interest Disclosure Act and Low Staff Feedback Management reported very low engagement with the Working in Confidence platform’s evaluation function during 2025, significantly limiting insight into staff experience of the Speaking Up Safely process. At the same time, management confirmed they cannot evidence compliance with Section 47B of the Public Interest Disclosure Act (PIDA) 1998, which protects staff from detriment after raising a concern. Although the organisation’s WP4a procedure clearly outlines these protections, the low level of staff feedback prevents meaningful assessment of whether these protections are being upheld in practice. Additionally, the organisation lacks a systematic monitoring or assurance mechanism to track potential detriment, limiting its ability to identify patterns, intervene early, or provide assurance to governance forums.	The agreed actions address the lack of assurance over compliance with the Public Interest Disclosure Act (PIDA) 1998 and the limited insight into staff experience arising from the fully anonymous nature of the Speaking Up Safely platform, which restricts the organisation’s ability to identify potential detriment and assess whether protections are effective in practice. 1. Define and implement a proportionate assurance framework for PIDA compliance, setting out how protection from detriment will be monitored and evidenced within the constraints of an anonymous reporting system. 2. Strengthen encouragement of voluntary staff feedback within the Speaking Up Safely platform, clearly communicating the value of feedback while recognising that responses cannot be mandated. 3. Improve management information derived from available platform data, including case progression, timeliness, themes, and repeat concern indicators, to support proxy assurance where direct feedback is not available. 4. Establish alternative assurance mechanisms to identify potential detriment, such as triangulation with workforce data, employee relations activity, grievances, and staff survey intelligence. 5. Define escalation triggers and review arrangements where indicators suggest potential detriment, repeat concerns, or reduced confidence in the Speaking Up Safely process. 6. Implement routine reporting to the Executive Team and relevant Committees on PIDA assurance, feedback levels, potential detriment indicators, and mitigating actions. Combined, these actions will strengthen assurance of PIDA	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>

1808	Planned Care Major Change Programme – Governance and Delivery	2026	Limited	High	Objective 2: There are effective controls in place to manage delivery within each workstream, i.e. progress reviews, resource reviews, delivery against objectives. We will consider the evidence and data available to support delivery.	2. Project Delivery Projects and initiatives have progressed, but delivery has not been consistently achieved within the planned timescales. Of the twelve projects planned for completion by January 2026, only two were delivered, with nine rolled forward to quarter four. Delivery data presented in the February 2026 Highlight Report showed a slight improvement in performance; however, overall delivery remained below planned expectations.	2.1 Undertake full engagement with the Planned Care Programme Board members on the priorities for inclusion in the 2026/27 plan, aligned to the refreshed IMTP (published April 2026), committing to only those activities that have secure funding and resources to ensure delivery; set out in the project tracker with clear milestones and delivery dates for reporting via the Highlight reports, T&I Performance portal and AAA reports.	Tehmeena Ajmal, Chief Operating Officer	31/05/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1809	Planned Care Major Change Programme – Governance and Delivery	2026	Limited	High	Objective 2: There are effective controls in place to manage delivery within each workstream, i.e. progress reviews, resource reviews, delivery against objectives. We will consider the evidence and data available to support delivery.	3. Workstream Leads We confirmed that five of the six workstreams have named leads. Workstream 6 is overseen by a collaborative group of subject matter experts rather than a single lead. However, the lead responsible for Workstreams 3 and 5 left the organisation in December 2025, resulting in a leadership gap that may impact timely delivery of enabling actions.	3.1 Identification of Workstream Leads for 3 and 5 relevant to the workstream aim and content; with a co, or deputy lead identified to mitigate the risk of loss of leadership.	Tehmeena Ajmal, Chief Operating Officer	31/05/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1810	Planned Care Major Change Programme – Governance and Delivery	2026	Limited	High	Objective 3: There is reporting to the Board on performance of the workstreams / Programme and delivery of outcomes/improvements.	4. Board and Committee Reporting The Board and its Committees have not been routinely sighted on delivery progress. Limited detailed workstream updates, assurance, and escalation of issues affecting delivery have been provided throughout the year. The Quarter 3 ADP Progress Report, presented to PFIG on 24 February 2026, provided a more comprehensive update than earlier submissions. The accompanying Monitoring Report assigned confidence ratings to each IMTP deliverable, including the eighteen Planned Care priorities, and summarised progress, key remaining focus areas, and anticipated impact. However, this was the first point in the financial year at which the Board and its Committees received this level of detail.	4.1 Implement a quarterly ADP monitoring report for PFIG/PPHP which incorporates: • RAG rating for Delivery Confidence against all priorities within the IMTP • Current position in terms of progress, including constraints to delivery and escalation of issues • An outline of work required for the remainder of the year including any risks to future delivery • A description of the impact achieved through delivery of the priorities	Tehmeena Ajmal, Chief Operating Officer	31/05/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1815	Executive Committee: Governance	2026	Limited	High	Objective 1: The Executive Committee is operating effectively in line with the delegated powers from the Board, as set out within its Terms of Reference.	1. Executive Committee - Standing Order Conflict The Executive Committee established by the Health Board is not compliant with Standing Order (SO) SO 3.4.6 that states “Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers”. As the Chair of the Executive Committee (EC) is the Chief Executive and Membership is the Executive and Corporate Directors it cannot be established as a Health Board Committee.	1. Review the Terms of Reference to ensure that it is clear that this is a management committee established by the Chief Executive Officer. 2. The Board will still receive regular reports as part of the transparency and reporting; these will be appended to the CEO from July 2026.	Pam Wenger, Director of Corporate Governance	31/07/2026	<i>New report - progress update to be provided for August Audit Committee</i>

1816	Executive Committee: Governance	2026	Limited	High	Objective 1: The Executive Committee is operating effectively in line with the delegated powers from the Board, as set out within its Terms of Reference.	2. Executive Committee (EC) Terms of Reference (and supporting governance architecture) Whilst noting the current EC Terms of Reference (ToR) remain extant but are the subject of planned review by the Office of the Director of Corporate Governance; we found the EC is hindered by the lack of reporting for most established groups/programmes, coupled with expected matters that are difficult to evidence achievement. The following key findings were also noted: • ToR are not reflective of the current executive/corporate structure. • There is no cycle of business detailing what is expected at each meeting, allowing for emerging issues with minimum reporting requirements evident. • There is no evidence of performance or finance consideration at the meeting despite this being a specific matter. • A clear organogram detailing all the groups/programmes established by the executive and the flow of reporting and what assurance they provide (identifying those that are not decision making, with reporting then routed via the relevant executive).	As part of the establishment of reporting groups into the Executive Committee; clear arrangements will be set out including cycle of business and other matters as required in the terms of reference	Pam Wenger, Director of Corporate Governance	31/07/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1817	Executive Committee: Governance	2026	Limited	High	Objective 2: The groups that report directly to the Executive Committee are providing regular updates to ensure the Committee is sighted on significant issues and items requiring approval by the Committee and/or escalation.	3. Established Groups reporting to the Executive Committee (EC) Fourteen Groups and Major Programmes are scheduled to report to the EC although we found new groups having been established but not reflected in the ToR. There is no reporting from these Groups/Programmes into the EC; only the Quality Executive Delivery Group, Risk Scrutiny Group and Executive Policy Oversight Group (via Statutory Compliance Report) reporting regularly. In reviewing papers from the Groups/Programmes, we found the following issues considered at the Groups/Programmes but were not evident through agenda items considered/reported to the EC (and falling within the EC delegated matters): • Agreement to increase catering prices across the Health Board from 5 January 2026 with no evidence of compliance with Standing Financial Instruction 9.3 – Fees and Charges. • Reforecasting a £17m deficit for the Health Board. • Consideration of the recommendations to the Future Generations Commissioner report with no evident reporting to a Health Board Committee found. • The Capital Investment Group is not complying with its Terms of Reference; it has not been chaired by the Executive Director for some time, with its ToR not including the remit set out in the EC ToR.	Review of the Executive Groups with clear terms of reference and frequency of reporting	Pam Wenger, Director of Corporate Governance	31/07/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1818	Executive Committee: Governance	2026	Limited	High	Objective 2: The groups that report directly to the Executive Committee are providing regular updates to ensure the Committee is sighted on significant issues and items requiring approval by the Committee and/or escalation.	4. Programmes/Groups Terms of Reference A review of some Group/Programme terms of reference found that membership frequently overlapped with EC membership— for example, in the Integrated Performance Executive Delivery Group and the Strategic Planning and Service Change Group. This same membership increases the risk of self-reporting, self assurance and undermines the three-lines model and additional scrutiny. We also noted the Chief Executive is recorded as Chair for several Groups/Programmes and the Chair of EC. Whilst noting this was partly due to executive/corporate director post vacancies, there is now a substantive executive and corporate director team in situ, enabling the delegation to chair the groups/programmes.	1. Review of the Executive Groups with clear terms of reference and frequency of reporting (linked to 3 above) 2. Review of the leads of each of the EDG and membership to ensure appropriate delegation	Pam Wenger, Director of Corporate Governance	31/07/2026	<i>New report - progress update to be provided for August Audit Committee</i>

1819	Budget Setting	2026	Limited	High	Objective 1: The health board has an appropriate financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements.	1. Budget Deficit - savings The Health Board's opening financial position was heavily reliant on savings and central adjustments to balance the budget. The budget-setting calculation shows an initial income and expenditure gap of £8.611m, a £40.0m savings requirement, and significant use of central reserves, including £62.254m of financial plan funding at the start of the year. This pressure was evident early in-year, with a £3.7m start of financial year deficit, of which £2.7m related to unachieved savings. Together, this indicates a risk that the financial plan may not be delivered if savings are not achieved and underlying pressures continue.	Divisional savings targets are established prior to the commencement of the financial year and communicated to Divisional Directors accordingly. Delivery of these savings is monitored on a monthly basis against the agreed plan, performance reported and scrutinised through a range of governance forums, including IPEDG, Value & Sustainability Board, Finance Oversight Group, PFIG, and the Health Board. Savings delivery is also one of the key metrics to be reviewed as part of the Accountability Framework. Monthly reports are prepared by Finance Leads at a divisional level and presented to the respective Senior Leadership Teams, with presentation at the Operational Leadership Forum the importance of identifying opportunities for savings delivery early for the next financial year. To support the timely development and agreement of savings plans, divisional savings targets will be issued earlier in the financial year, enabling a greater proportion of plans to be developed in advance of commencement of the financial year.	Russell Caldicott, Executive Director of Finance	31/03/2027	<i>New report - progress update to be provided for August Audit Committee</i>
1826	Standards of Business Conduct (2026)	2026	Limited	High	Objective 3: Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly and escalated where appropriate.	3. Review and escalation of non-compliance Whilst some evidence of the Corporate Governance Team addressing queries with declarations were provided, and reports with submitted declarations are reviewed, there does not appear to be any identification of breaches and escalation to relevant areas. We note that this is difficult due to restrictions with the system and it is noted that it is planned that the Corporate Governance Team will be monitoring for any breaches of the policy. A review of the system report provided to the Corporate Governance Team in March 2026 details declarations that have not been approved. At the time of reporting a number of these declarations, including loyalty interests and outside employment dating back to April and May 2025, had not yet been approved or escalated.	A formal process will be implemented for the identification, monitoring and escalation of non-compliance with the Standards of Business Conduct Policy. This will include regular review of overdue and unapproved declarations, defined escalation routes to Executive Directors and operational leads, and documented follow-up actions. Limitations of the current system will be mitigated through manual oversight controls until system improvements are delivered.	Pam Wenger, Director of Corporate Governance	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1827	Standards of Business Conduct (2026)	2026	Limited	High	Objective 3: Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly and escalated where appropriate.	4. Declaration of Interest Compliance – band 8c and above Current compliance with Declarations of Interest for band 8c and above (decision makers) is at 54%. We are advised it is difficult to obtain accurate figures as the information in the system is reconciled to the Electronic Staff Record system, which can include duplicate staff.	Action will be taken to improve declaration of interest compliance rates for staff at Band 8c and above. This will include reconciling Declare system data with ESR to improve accuracy, targeted follow-up with non-compliant individuals, and escalation to Executive Directors where required. Compliance levels will be monitored and reported as part of routine governance reporting	Pam Wenger, Director of Corporate Governance	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1828	Standards of Business Conduct (2026)	2026	Limited	High	Objective 3: Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly and escalated where appropriate.	5. Declaration of Interest Compliance - private practice A review of 61 consultants listed in a local private hospital directory as having a base of a Health Board hospital were reviewed. Of these 61, 29 had not declared their private practice interest on the DOI system.	The Health Board will strengthen arrangements to ensure consultants undertaking private practice declare these interests in line with policy requirements. This will include targeted communication to the Medical and Dental workforce, alignment with job planning and appraisal processes, and operational management oversight. Non-compliance will be escalated in line with the revised escalation framework.	Pam Wenger, Director of Corporate Governance	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1829	Standards of Business Conduct (2026)	2026	Limited	High	Objective 4: Submissions of gifts and hospitality are reviewed to ensure they are in line with policy requirements, and suitable action taken where issues are identified.	6. Gifts, hospitality and sponsored events The Standards of Business Conduct Policy sets out clear guidance and monitoring arrangement for the declaration of gifts, hospitality and sponsored events. From our testing, there is a delay staff declaring gifts, hospitality and sponsored events, often until some time after the event. There is also limited evidence to demonstrate these are being reviewed by the Corporate Governance Team on a	Arrangements for the monitoring and review of gifts, hospitality and sponsored event declarations will be strengthened to ensure timely declaration and consistent review. The Corporate Governance Team will undertake regular reviews in line with policy requirements and act where decisions breach policy or timescales are not met. Expectations will be reinforced with staff through refreshed guidance.	Pam Wenger, Director of Corporate Governance	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>

1830	Non DDaT Controlled IT	2026	Limited	High	Objective 1: IT systems and digital tools procured or managed outside the central IT function (DDaT) are required to comply with relevant digital policies, procedures and guidance and are included within the overall digital governance and oversight arrangements to ensure accuracy of data, security and fully used consistent with overall strategy	1. Provision of Guidance The policies in place make clear that all staff who are responsible for managing digital systems have to protect the information / data, however they do not set out any specific requirements, neither is there any guidance information provided by DDaT to other departments. As such due in part to the lack of knowledge of requirements we noted that there were weaknesses in the management and control of digital applications outside of DDaT.	Execs - to clearly state that DDaT are the professional leaders for all digital items, and to communicate to all staff that all departments must follow DDaT guidance. DDaT Review of All Digital Guidance, Policies and Procedures - A full review will be undertaken of all existing guidance, policies and procedures relating to managing digital systems across the Health Board. Creation of a Central Intranet Location - A single, central location will be established on the intranet to hold all digital policies, procedures and supporting guidance, making them easy for system owners to locate.	Justine Parry, Acting Director of Digital, Data and Technology; Tehmeena Amjal, Chief Operating Officer; Teresa Owen, Executive Director of Allied Health Professions & Health Science	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1831	Non DDaT Controlled IT	2026	Limited	Medium	Objective 1: IT systems and digital tools procured or managed outside the central IT function (DDaT) are required to comply with relevant digital policies, procedures and guidance and are included within the overall digital governance and oversight arrangements to ensure accuracy of data, security and fully used consistent with overall strategy	2. Oversight Mechanisms There is no executive led forum or Teams Channel which includes representation from across the Health Board, acting as a steering group for Digital which can ensure strategic alignment for new digital items and ensure compliance with required standards from all across the organisation. As such there is limited ability for DDaT to act as the professional guide for digital across the Health Board and provided guidance to ensure that all digital systems are appropriately controlled.	1. DDaT - Establish a Teams channel for digital management for relevant staff across the Health Board to participate in and which acts as a channel for digital to provide leadership and professional guidance. 2. All Directors to ensure that all IAOs and system managers join the Teams Channel, and comply with DDaT requirements and guidance. DDaT Ensure that System Owners are included in the membership of existing Digital Champions, IG Champions and Cyber Champions Viva Engage groups and continue to disseminate professional guidance. Organisation-Wide Communication to System Owners - Communications will be issued to all system owners setting out the requirement to comply with digital policies, procedures and guidance. Targeted Communications to Asset Owners - Further targeted communications will be sent to digital asset owners to ensure they understand the information relevant to	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	30/09/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1832	Non DDaT Controlled IT	2026	Limited	High	Objective 2: Procurement and contract management processes prevent unauthorised or duplicate IT systems from being acquired and supported outside of digital services oversight	3. Procurement Process There is no formal procedure stating the requirement for buyers to confirm and record DDaT approval for software prior to purchase.	To issue a communication to all Budget Holders confirming that all that all departments must comply with requirement to contact DDaT for approval before purchasing digital items (Director of Corporate Governance) To develop a formal procedure for buyers to ensure that all digital items receive DDaT approval prior to requisition. In the event of this not being provided, notification of non compliance	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	30/09/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1833	Non DDaT Controlled IT	2026	Limited	High	Objective 2: Procurement and contract management processes prevent unauthorised or duplicate IT systems from being acquired and supported outside of digital services oversight	4. Cyber Essentials+ Requirement There is a Welsh Government requirement (set out in WHC (2017) 025 Cyber Security & Information Governance) for suppliers of digital systems to be CE+ certified, however not all contracts include this as a mandated requirement within the specification, with it instead being included as a high priority requirement. As specifications can have a large number of requirements, this means that the CE+ aspect may not be fully	To ensure all procurement digital contracts to include a requirement CE+. If this is not achievable then SIRO approval to be obtained prior to the tender process.	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	30/09/2026	<i>New report - progress update to be provided for August Audit Committee</i>

1835	Non DDaT Controlled IT	2026	Limited	High	Objective 4: Processes are in place to identify shadow IT and ensure risks are managed appropriately (cyber-security, compliance).	6. Identification of Digital Systems There is currently no mechanism to analyse Health Board devices to establish what software is in use such as the SNOW software in use elsewhere within NHS Wales, as such DDaT are reliant on other departments providing the information and notifying them of digital items in use. We further note that the asset register in place contains incomplete information in some cases, with no asset owner or administrator named, or incorrect names included. We note that DDaT have previously tried to obtain this information but responses have been limited. From our work cross referencing the separate records of digital items we note that they are not consistent, with not all items included in the IAR or the cyber scorecard and incomplete information regarding ownership. As such there is no complete, accurate record of what digital systems and suppliers are in use across the whole organisation.	1. Formulate a mail to senior managers requiring staff to complete the form / IAR with information on all their digital applications. 2. Send the mail (drafted by DDaT) asking for details on digital application with a clear statement that managers must comply. DDaT ICT have the capability to review locally installed software through SSCM and Defender. The gap here relates to our ability to identify where staff are using CLOUD based software without permission. This is a difficult balance i.e. draconian web filtering policies which prevent staff from working vs. controlling access to unsanctioned Apps. action:-Investigate technology solutions which would allow the catalogue and monitoring of Cloud based software by staff.	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	30/09/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1836	Non DDaT Controlled IT	2026	Limited	High	Objective 4: Processes are in place to identify shadow IT and ensure risks are managed appropriately (cyber-security, compliance).	7. Software Risk There is a wide range of software in use, with many suppliers not holding the CE+ certification, having no malware protection and not undertaking timely patching and are therefore not complying with minimum security requirements. In many cases these risks are not being recorded within departmental risk registers and so the true risk to the Health Board is unquantified. We also note that there is no process to enable DDaT to enforce minimum requirements across the Health Board, and there is no process or resource within DDaT to enable the resolution of these issues and coordinate digital systems across the whole organisation.	1. Each Director to undertake a review of systems and identify areas of non-compliance with CE+ and this will be reported to the appropriate governance group. DDaT Risk assessments of existing systems will be undertaken, with any identified risks highlighted to System Owners for inclusion on their local risk registers. The Cyber Security Team will also contact suppliers to outline any identified gaps and emphasise the commercial benefits of improving their security posture in line with WHC 2017.25. Audit spot checks will be introduced to confirm that System Owners are accurately recording risks on their local registers and that risk scoring is applied consistently. Where non-compliant systems are procured, these will be recorded in the Information Security Management System (ISMS) non-conformity log. Entries will be cross-checked with the asset register and reported to Executives through quarterly IGG reports.	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	30/09/2026	<i>New report - progress update to be provided for August Audit Committee</i>
1839	Non DDaT Controlled IT	2026	Limited	High	Objective 7: Medical devices are equipped with the latest software versions, where applicable.	9. Device Records There is no complete record of medical devices and the software installed which would enable the full risk picture to the organisation to be established. Similarly there is no complete, easily accessible records of the pacemakers in use across the Health Board	To deliver the implementation of Scan for Safety as agreed at the Executive Committee ensuring that capture of operating system and records will be place.	Dylan Roberts, Chief Digital and Information Officer / Justine Parry, Acting Director of Digital, Data and Technology	31/12/2026	<i>New report - progress update to be provided for August Audit Committee</i>

OPEN EXTERNAL AUDIT RECOMMENDATIONS

ID	Report Title	Year	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implement ation date	Latest update
0403	Structured Assessment 2023	2023	Financial strategy	R7: It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit.	R7: Agreed. The Board approved the financial plan in May 2023 with the Annual Plan approved at the end of June 2023 following agreement with Welsh Government. The HB developed revised plans in year with the expressed intention of balancing improvements in quality and performance within an affordable financial envelope. The focus from close of 23/24 financial year and moving into 24/25 and beyond has been to endorse a value and sustainability approach to delivery of improvements for staff, patients and visitors that will also result in a sustainable financial for future health care.	Russell Caldicott, Interim Executive Director of Finance	31/07/2024	<i>This was originally closed through the closure approval process, but reopened as per the Director of Corporate Governance's instructions that, as part of the work around the SA 2025, there was insufficient evidence around this. An update on progress will be provided for the next meeting.</i>
1453	Structured Assessment 2024	2024	Recommendation 2	R2. In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role.	R2: Currently there is no accountability or responsibility for the Senior Leadership Team in terms of operational governance, it is a mechanism by which the Members of the Executive Team can engage to support the delivery of the Health Board plans. As part of the Foundations for the Future Programme, clarity on roles and responsibilities for groups will be confirmed alongside the role of the Senior Leadership Team and the Operational Leadership Team. Key actions include: • Review of the operational governance arrangements including the role of the Senior Leadership Team	Pam Wenger, Director of Corporate Governance	31/07/2025	Operational Governance Framework key principles was received and supported at informal Executive Committee on 18 March 2026. It was agreed to hold workshop on key principles by end of May 2026 with current senior service leads. A final draft will be received at Executive Committee on 17 June 2026. Once approved, final amendments to be made and formal communication and engagement plan to be developed. Audit Committee will receive an update on this.
1456	Structured Assessment 2024	2024	Recommendation 5	R5. The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board.	R5: The Health Board is considering the most appropriate way to engage the wider Board in terms of visiting services. Individual Board Members visit sites on a regular basis. Key actions include: • Agree how the Board can engage with services, which will include plans in terms of service reviews; • Establish a reporting mechanism to the Board in terms of service visits	Pam Wenger, Director of Corporate Governance	30/06/2025	Service areas have been identified for visits, dates and timings are being coordinated, and a full update will be provided through the Governance Report to the May Board.
1463	Review of Cost Savings Arrangements	2024	Recommendation 1.2	R1.2: The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.2: Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target.	R1.2 The articulation of demand and capacity by speciality and comparison to national metrics will enable allocative efficiency models to be endorsed. This will depend largely upon formation of the above speciality plans and Corporate benchmarking that will occur prior to and during 2025/26.	Russell Caldicott, Executive Director of Finance	31/10/2025	Work had commenced on elements of an allocative efficiency model for 2026/27, however this was overtaken by a total productivity factor model that has been developed across Wales by the FD & P. This model, together with other available benchmarking information will be available for IHCs to support in the identification of savings opportunities
1470	Review of Cost Savings Arrangements	2024	Recommendation 3.1	R3.1: When updating its savings guidance, the Health Board should ensure: R3.1: That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas.	R3.1 The Health Board launched Small Change Big Difference in 2023, which sought ideas from all staff. We will continue to progress and follow up on these initiatives to secure enhanced savings delivery.	Russell Caldicott, Executive Director of Finance	Ongoing 2025	The proposal for the refresh of the 'Small Change big difference' was scheduled for the October Programme board, but has yet to be heard due to cancellation of the board and this particular item being deferred. A request has been made for the chair to schedule the paper urgently.

1514	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520) 2. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs. (OWNER: CHC Commisioning Manager)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	Recommendation for this action to close. We have just completed a joint review of all the recommendation within the WAO Flow out of Hospital. This will be presented to RPB in May. The recommendation will be to close all the actions and anything outstanding will transfer to the Pathways of Care Action Plan The Health Board as part of Winter Sprints 1 & 2 provide the 6 LAs to the Right Patient Right Dashboard which is updated multiple times over a 24 hour period. It provides information on a LA and CRT foot print and includes patients who are Clinically optimised, D2RA pathway and what each patient is waiting for e.g. Social worker Allocation, Nursing Assessment, Care Home Placement. Progress and support to close the action will go to RPB in May.
1717	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	R9 To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task.	R9: A clinical lead has been identified to roll out our Single Point of Access model, which includes an accurate and up to date directory of services to support referral into appropriate services. This will initially be supported by the 6 Goals project team. The lead role will be designated following the reconfiguration of services.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026	SPOA is currently delivering Q1 milestones. A workshop is planned with wider partners early june to ensure ownership moving forward. 6 goals funding will fund a temporay implemetation lead to assist in the operationalising of the spoa model and how we fully integrate the SICAT model into the wider SPOA intentions.
1718	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	R10 To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee	R10: As part of the 6 Goals programme a review will be undertaken to evaluate the SDEC models currently in place on each of the 3 acute sites in North Wales, including an analysis of utilisation by WAST and ED to support streaming, and outcomes for patients. The NHS P&I team are conducting an assurance review of the SDEC units during October 2025.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026	SDEC review currently being completed. BCUHB are not fully activating the SDEC model and a clear SOP needs developing to be adopted by all IHC's to complie the the report recommendations from NHS P& I in Novrmber 2025. this is still a pivotal part of the UEC improvement work
1719	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	To ensure Urgent Primary Care Centres are being maximised, the Health Board should: R11.1 Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria.	R11.1: BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026	<i>No progress update received</i>
1720	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	To ensure Urgent Primary Care Centres are being maximised, the Health Board should: R11.2 Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed.	R11.2: BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026	<i>No progress update received</i>
1724	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Reporting of expenditure of additional funding for UEC services	R15 To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies	R15: The UEC (6 goals) programme board approved the 6 Goals financial plan that is aligned to the 6 Goals programme plan prior to submission to WG earlier this year. The UEC / 6 Goals programme board will receive regular finance reports on UEC / 6 Goals and wider Further Faster / RIF funding as a standing item which includes review with LA partners.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025	UEC improvement plan (formally 6 goals plan) accepted for 2026/27. funding agreed and 90 day plans (alligned to quarterly deliverables) currently being development by the WS leads. All monies aligned to the programme will be used for the UEC deliverbles and disinvestment has taken place in SICAT to grow the SPOA at pace through Q2.
1725	Tackling the Planned Care Challenges	2025	Planning	R1. Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		A 'draft' delivery plan for 2026–27 was presented at the PCPB in April for directional sense-check (not funding approval), with all members committing to review and feedback. The drafted activity aligns with the Health Boards IMTP. There was collective agreement that future delivery must focus on fewer, higher-impact priorities assessed through a consistent value-based approach.

1726	Tackling the Planned Care Challenges	2025	Demand and capacity	R2. The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The HB recognises the need for demand and capacity modelling and specialty level trajectories and this is included on the corporate risk register (CRR25-01) with an action to complete demand and capacity analysis across Planned Care to inform forward activity planning to clarify detailed understanding of specialty level- demand and capacity, enabling improved activity planning, reduced long waits, and more efficient use of core capacity. Progress has taken place with a Demand & capacity (D&C) planning session held in April to review core demand and capacity planning across specialties within Q1 to confirm the position for 2026/27. A further session is scheduled in May with a specific focus on Cancer and Diagnostics to enable more detailed discussions on demand and capacity for 26/27. This will be supported by a ‘planned care sprint’ to improve booking of long waiters into core capacity and transfers of care to
1727	Tackling the Planned Care Challenges	2025	Programme governance and programme business cases	The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: R3.1 Strengthening the Programme Board’s delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		From Q1 2026-27, the role of Senior Responsible Officer (SRO) handed over from the Chief Executive to the Chief Operating Officer, with the new SRO to function as ‘Executive Sponsor’ across the Planned Care, Urgent & Emergency Care and Community by Design Major Change Programmes. This will support clearer interfaces between programmes in delivering the organisations priorities ToRs have been revised for sign off
1728	Tackling the Planned Care Challenges	2025	Programme governance and programme business cases	The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: R3.2 Developing a clear planned care improvement programme for delivery, monitoring and associated accountability.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		A ‘draft’ delivery plan for 2026–27 was presented at the PCPB for directional sense-check (not funding approval), with all members committing to review and feedback. The drafted activity aligns with the Health Boards IMTP. There was collective agreement that future delivery must focus on fewer, higher-impact priorities assessed through a consistent value-based approach 6 Workstreams have been identified to focus on the planned care programme priorities which are aligned to the IMTP deliverables
1729	Tackling the Planned Care Challenges	2025	Programme governance and programme business cases	The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: R3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		Business case refresher training is being explored with the Planning Directorate for those staff that are required to complete business cases

1730	Tackling the Planned Care Challenges	2025	Programme governance and programme business cases	The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: R3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The Planned Care Programme Board reviews cost pressures at their meeting and in 2025/26 submitted on behalf of the board its cost pressures for the IMTP planning in early December to inform prioritisation of the plan for 2026/27, which will focus on funded or cost neutral projects.
1731	Tackling the Planned Care Challenges	2025	Programme Board clinical leadership	The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by: R4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The Planned Care Clinical Director was appointed with a Job Description and person specification, with the role reporting in to the Executive Medical Director.
1732	Tackling the Planned Care Challenges	2025	Programme Board clinical leadership	The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by: R4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The development of Clinical Service Plans has been identified as a Major Change Programme for 2026/27. Initial clinical orientation engagement held 05th May 2026
1733	Tackling the Planned Care Challenges	2025	Risk management	R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The COO has met with the corproate risk manager to work towards arrangements to take assurance that the IHC and associated services are reviewing their risks and reducing risk levels
1734	Tackling the Planned Care Challenges	2025	Monitoring impact of additional funding	R6 The Health Board should strengthen its monitoring of the use and impact of the additional Welsh Government planned care funding	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The Health Board has established and embedded arrangements to monitor the use of additional Welsh Government planned care funding. Financial performance against the allocation is monitored internally and formally reported monthly to Welsh Government through the Monitoring Return submissions, providing clear oversight of spend and forecast outturn. In parallel, the Health Board routinely reports on activity delivery and the impact of planned care investment through regular meetings and reviews with Welsh Government NHS Performance & Improvement colleagues. These arrangements provide ongoing assurance over both the appropriate use of funding and its contribution to improving patient access and will continue to be strengthened through closer alignment of financial and activity reporting within existing governance structures.

1735	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		Nationally the Clinical Improvement Networks (CINs) have released the CIN Optimisation Framework Self Assessments for completion by all Health Boards. These bring together the requirements of GIRFT (reflecting any Welsh variation), Enabling Actions and Ministerial Advisory Group Recommendations within standardised templates to be submitted by the 15th May 2026. BCU have completed the initial collection and are on track to submit, with local arrangements for review of the outcomes to build into local plans being confirmed.
1736	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		Measures are in place via the IRIS Power BI 'Theatres' dashboard with a 'Cancellations' report at patient level, accessible and used within each IHC
1737	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand and address the root cause of surgical cancellations.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		IHCs use the IRIS Power BI 'Theatres' dashboard 'Cancellations' report at patient level provides the cancellation reason, which can be filtered and reviewed to ascertain patterns and actions to be taken at a speciality and consultant level
1738	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.4 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85%.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		Nationally the Clinical Improvement Networks (CINs) have released the CIN Optimisation Framework Self Assessments for completion by all Health Boards. These bring together the requirements of GIRFT (reflecting any Welsh variation), Enabling Actions and Ministerial Advisory Group Recommendations within standardised templates to be submitted by the 15th May 2026. BCU have completed the initial collection and are on track to submit, with local arrangements for review of the outcomes to build into local plans being confirmed. The outcome of the self-assessments will provide additional information to support the Demand & Capacity workshops, identifying the gaps, best practice and opportunities to improve utilisation through 'just do it' actions operationally and longer-term strategies within the Planned Care Programme
1739	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.5 Develop and rollout approaches to increase the use of “virtual” outpatient appointments, where clinically appropriate.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The use of video appointments has seen an 86% increase from March 2025 to March 2026. Work for 2026/27 plans will align the opportunity for virtual follow-ups with the updated national CIN discharge protocols (v2.0 May 2026) and SOS/PIFU re-engagements
1740	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.6 Develop job planning policy and guidance.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		<i>No progress update received</i>

1741	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.7 Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align consultant capacity to meet service demand.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		These are reviewed on an annual basis within each IHC
1742	Tackling the Planned Care Challenges	2025	Efficiency and productivity	Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should: R7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		Task & Finish group has been established to map out the technical and underpinning transactional service implications of moving to pooled waiting lists within WPAS. Meetings are being held weekly, with the third scheduled for 08/05. Aligning to this will be the clinical engagement being carried out in bespoke areas such as via the Llandudno Hub Project (T&O Challenged Service), and more longer-term and broadly, in the work that will emerge from FftF and Clinical Services Plan
1743	Tackling the Planned Care Challenges	2025	Promote, Prevent and Prepare for Planned Care policy	R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		WG funding for the single point of contact services ceased March 2026. Local extensions have been secured to the end of June 2026 with a report for ongoing arrangement is being considered by OLT.
1744	Tackling the Planned Care Challenges	2025	Risk of harm	In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should: R9.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		<i>No progress update received</i>
1745	Tackling the Planned Care Challenges	2025	Risk of harm	In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should: R9.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		<i>No progress update received</i>
1746	Tackling the Planned Care Challenges	2025	Risk of harm	In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should: R9.3 Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised.	No management response within report	Tehmeena Ajmal, Chief Operating Officer		The development of Clinical Service Plans has been identified as a Major Change Programme for 2026/27. Initial clinical orientation engagement held 05th May 2026. In readiness for this the challenges service Improvement Plans include the impact on reducing the risk of harm through the actions identified to improve sustainable service deliver; where appropriate developing specific harms review approaches.

1798	Structured Assessment 2025	2026	Recommendation 3	R3 The Health Board should increase the pace of its process to update high-risk policies.	R3. The Health Board has made progress on reducing the number of overdue policies. The Health Board will aim to eliminate the number of high-risk policies by end 2027 (with the exception of All Wales Policies) aligned to the improvement in policies processes.	Pam Wenger, Director of Corporate Governance	30/06/2026	A request for updates on overdue policies is submitted from the Statutory Compliance Team in readiness for reporting to Executive Committee and Audit Committee. A number of overdue policies remain, with some overdue a review since 2017. The Policy and Compliance Manager will work with the policy owner for policies due a review in 2017 to identify whether these policies are still extant, to include whether they need to be updated, reviewed or removed as no longer required. Progress has been made on reducing the number of overdue, high-risk policies, with a reduction from 15 in the last report to Audit Committee, to 6 in current report. However, new overdue high-risk policies are added onto the last on a monthly basis, therefore the number is likely to fluctuate over time.
1801	Structured Assessment 2025	2026	Recommendation 5 (5.2)	R5 The Health Board should ensure that its executive leadership arrangements are supporting a collective and shared response to the organisation's key challenges. This must include: 5.2 Ensuring all Executive portfolios are deliverable and appropriate, support a fair distribution of responsibilities across the Executive Team and avoid the risk that leadership of the response to the organisations main challenges becomes vested in just a few individuals.	R5.2 Review of Executive portfolios has been completed as part of Foundations for the Future Programme, where necessary functions have been re-aligned and will be taken forward as part of the 'deliver' phase of the Foundations for Future Programme.	Pam Wenger, Director of Corporate Governance	30/06/2026	<i>Update will be provided for August Audit Committee</i>
1802	Structured Assessment 2025	2026	Recommendation 5 (5.3)	R5 The Health Board should ensure that its executive leadership arrangements are supporting a collective and shared response to the organisation's key challenges. This must include: 5.3 Identifying a Deputy Chief Executive.	R5.3 The Chief Executive will consider the designation of the Deputy Chief Executive now that the Executive Team is in place.	Pam Wenger, Director of Corporate Governance	30/09/2026	<i>Update will be provided for August Audit Committee</i>
1803	Structured Assessment 2025	2026	Recommendation 6	R6 The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports).	R6 Lead Executives will be identified for attendance at meetings where there is a specific report being presented that requires their input.	Pam Wenger, Director of Corporate Governance	30/06/2026	<i>Update will be provided for August Audit Committee</i>
1804	Structured Assessment 2025	2026	Recommendation 7	R7 The Health Board should ensure that it has the appropriate programme management and governance arrangements in place to support the roll out of the Foundations for the Future Programme. Specifically, it needs to ensure that: 7.1 It has sufficient management capacity to support the timely roll out of the Programme. 7.2 All Executive Team members are appropriately sighted of, and aligned with, the changes that the Programme intends to bring about. 7.3 Independent Members are appropriately briefed on the Programme and have sufficient opportunity to seek the assurances they need on its implementation.	R7 The Health Board has received reports on progress against the Foundations for the Future Programme; the frequency and regularity of reporting will increase as the programme moves through to the 'deliver' phase to consultation: From March 2026 onwards management capacity will be kept aligned to programme needs through ongoing review of workstream resourcing and strengthened Programme Team support where required. Executive alignment will be supported through an Executive review of the Programme Highlight Report and continued participation in Workstream Deep Dives. The People and Culture Committee will receive regular reports against the delivery of the programme with additional sessions arranged for the full board as necessary. Staff engagement will continue through the Programme's Communications Plan and dedicated intranet pages that provide accessible, up-to -date information.	Pam Wenger, Director of Corporate Governance	31/03/2027	<i>Update will be provided for August Audit Committee</i>

1805	Structured Assessment 2025	2026	Recommendation 8	R8 The Health Board should strengthen budget-setting approach to move away from the current position of rolling over existing budgets to one that is more zero based and reflects priorities and transformation needs in different parts of the organisation along with a more intelligence driven approach to savings planning.	R8 In 2025-26, an incremental budget setting approach was utilised, establishment costs and cost pressures (current and future) with developments aligned to available resource. Budgets to deliver services able to be re-configured within this process and amended throughout the financial year. The Health Board will deploy a zero-based budget setting methodology for 2027-28, which whilst time consuming will require every cost to be justified and aligned to delivery priorities. However, successful delivery will require a level of further maturity from budget holders combined with clear strategies to be in place to guide prioritisation of resource (Clinical and Estate) and clear lines of delegation and accountability. The Value & Sustainability programme of works will drive improvement, combined with benchmarking of services. The total financial benefits then analysed over the IMTP three financial years to remove the underlying deficit, strengthening future savings attainment and allowing application of allocative efficiency.	Pam Wenger, Director of Corporate Governance	31/03/2027	<i>Update will be provided for August Audit Committee</i>

Audit Committee

GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Pam Wenger, Director of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol **Executive Summary**

This paper presents proposed amendments to the Governance and Accountability Framework, including the Scheme of Reservation and Delegation (SORD), following a review of current decision-making arrangements. The amendments are intended to strengthen accountability, improve clarity of delegated authority and approval routes, and support decisions being taken at the most appropriate level within the organisation.

The proposed changes include recognising the Deputy Chief Executive as a Tier 2 officer for financial delegation purposes, with delegated authority up to £500,000; updating Oracle approval hierarchies to align with revised delegations; and extending authority within the consultancy approval framework to the Deputy Chief Executive for contracts up to £500,000. The amendments also clarify that Executive Committee approval is required only where proposals exceed the delegated authority of individual officers.

The paper also proposes an amendment to Table 12A(4) of the SORD to remove the requirement for Executive approval of individual Continuing Healthcare (CHC) placements up to £200,000 per annum where a compliant Pre-Placement Agreement is in place. Such placements would instead be approved through existing local and divisional delegated authority arrangements following established panel

scrutiny processes, while existing controls for higher-value, exceptional or non-compliant arrangements would remain unchanged.

Collectively, the amendments are designed to reduce ambiguity, support timely and proportionate decision-making, strengthen organisational resilience, and reinforce the principle that decisions should be taken at the lowest appropriate level of delegated authority, while ensuring that novel, contentious, repercussive or strategically significant matters continue to be escalated through the appropriate governance route.

The Committee is asked to approve the proposed amendments for onward approval by the Board in September 2026.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Head of Corporate Governance and Senior Financial Accountant – Charitable Funds and Financial Governance	06/02/26	Reviewing and finalising changes to the Governance Framework
Executive Committee	11/02/2026	Approved

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

SORD	Scheme of Reservation and Delegation
DCE	Deputy Chief Executive
WG	Welsh Government
Oracle	Health Board Financial Management System
EC	Executive Committee
Tier 2	Executive-level officer with delegated authority specified within the Scheme of Delegation
SoD	Scheme of Delegation
SFI	Standing Financial Instructions

GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

1. Y SEFYLLFA SITUATION

- 1.1 Following implementation of the revised Scheme of Reservation and Delegation (SoRD), a review has identified opportunities to improve the clarity and operation of the delegation framework. The proposed amendments are intended to strengthen accountability, provide greater clarity regarding delegated authority and approval routes, and ensure decisions are taken at the most appropriate level within the organisation. The changes include revisions to delegated financial limits, clarification of escalation arrangements through Executive Committee, and a number of updates to improve consistency and alignment with current organisational arrangements. The detailed amendments are set out in the table in this paper.

2 Y CEFNDIR BACKGROUND

- 2.1 Following review of current decision-making arrangements, it is proposed that delegated authority for specified matters is extended to the Deputy Chief Executive up to a value of £500k. This reflects the scope of the role, supports timely operational decision-making and provides greater resilience in the executive decision-making structure.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

- 3.1 Proposed changes are highlighted in Appendix 1, Schedule 1 - Scheme of Delegation and Reservation of Powers these are summarised as follows:
- The proposed amendments include recognising the Deputy Chief Executive as a **Tier 2 officer for financial delegation purposes**, with delegated authority up to £500k. This reflects the scope and responsibilities of the role, provides greater organisational resilience within executive decision-making arrangements and aligns delegated authority with accountability.
 - **Oracle approval hierarchies** will be updated to reflect the Deputy Chief Executive's designation as a Tier 2 officer, ensuring system-based approval limits are aligned with the revised Scheme of Reservation and Delegation and associated financial delegations (*reference 10A Schedule1*)
 - Inclusion of the Deputy Chief Executive within the **consultancy approval framework** with authority to approve contracts up to £500,000 (*reference 10I Schedule 1*)

- In addition to the amendments outlined above, *Table 5b* has been updated to recognise the Deputy Chief Executive as a Tier 2 officer for financial delegation purposes. This change provides delegated authority up to £500k, aligning the delegation with the responsibilities of the role and strengthening organisational resilience and executive decision-making capacity.
- Clarification that Executive Committee approval is required for proposals that exceed the delegated authority of individual officers, rather than applying a standalone financial threshold which may conflict with officer delegations (*Reference tables 12 (a)*)
- Approval is sought to amend *Table 12A(4)* of the SORD to remove the requirement for Executive approval of individual Continuing Healthcare (CHC) placements up to £200,000 per annum where a compliant Pre-Placement Agreement (PPA) is in place. Approval would instead be delegated through existing local and divisional arrangements, subject to established panel scrutiny and approval processes. Existing controls for placements above £200,000 per annum, exceptional cases, and arrangements without a compliant PPA would remain unchanged.

The proposed amendments removes ambiguity within the current Scheme by establishing a clear governance principle that matters should be approved at the lowest appropriate level of delegated authority. Decisions exceeding officer delegations, or which are novel, contentious, repercussive or strategically significant, will continue to be escalated through the appropriate governance route.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

There are no risks or matters for escalation.

5 ARGYMHELLION RECOMMENDATIONS

a. Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee is asked to:

- **APPROVE** the proposed changes to the Scheme of Reservation and Delegation (SoRD) for onward approval at the Board in September 2026

ASESIAD / ASSESSMENT

Cyswllt â'r Blaenoriaethau
Strategol



Trugaredd
Compassion



Agored
Openness



Parch
Respect

Link to Strategic Priorities	1. Building an effective organisation
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Public Sector Equality Duty: Compliance with the three parts of the Public Sector Equality Duty (General Duty): Public Sector Equality Duty [HTML] GOV.WALES <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Human Rights Act <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required

Compliance to giving 'due regard' to the principles of the Armed Forces Covenant <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Socio-economic disadvantage <i>Have you exercising your duties in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Choose an item.	Meysydd Ansawdd Domains of Quality Effective
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	Not required
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

STANDING ORDERS

Scheme of Reservation and Delegation of Powers

(Schedule 1 of the Standing Orders)

SCHEME OF RESERVATION AND DELEGATION OF POWERS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Date approved by Health Board:

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board, subject to any directions that may be made by the Welsh Ministers, shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of its aims and objectives. The Board may delegate functions to:

- i) A Committee, e.g., Performance, Finance and Information Governance Committee (PFIG);
- ii) A sub-Committee, e.g., a locality based Performance, Finance and Information Governance (PFIG) Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;
- iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs or Local Authorities established to take forward matters relating to services; and
- iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g., shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of the LHB's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in Standing Orders or Standing Financial Instructions.
- The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management
- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility
- The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development
- The Board must take appropriate action to assure itself that all matters delegated are effectively carried out
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes
- Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others
- The Board may delegate authority to act, but retains overall responsibility and accountability
- When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in Standing Financial Instructions).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Chief Executive or the Director of Corporate Governance of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

SCHEDULE OF MATTERS RESERVED TO THE BOARD¹

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (except for those decisions delegated to the NHS Wales Joint Commissioning Committee (the JCC)).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These will be set out within Schedule of Matters Reserved to the Board.
3	FULL	GENERAL	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ Standing Orders; ▪ Standing Financial Instructions; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

¹ Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal.
9	FULL	OPERATING ARRANGEMENTS	Approve the Standards of Business Conduct Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. from Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium-Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.

23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)

27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
28	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board

34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property
35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans

47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued

DELEGATION OF POWERS TO COMMITTEES AND OTHERS²

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- Audit Committee
- Charitable Funds Committee
- Mental Health Legislation Committee
- Quality, Safety and Experience Committee
- Partnership, People and Population Health Committee
- Performance, Finance and Information Governance Committee
- Executive Committee
- Remuneration Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the LHB's Scheme of Delegation to Committees.

² As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OPERATIONAL BUDGET MANAGERS

The LHB Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers.

The Chief Executive's Job Description, together with their Accountable Officer Memorandum, sets out their specific responsibilities. The individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the Standing Financial Instructions, form the basis of the LHB's Scheme of Delegation to Officers.

This element of the scheme of delegation only relates to matters delegated by the Board to the Chief Executive and the Executive Directors which are not covered by the Standing Financial Instructions.

Delegated Matter	Table Reference No.
MEETINGS	1
PERSONNEL	2
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	3
REPORTING INCIDENTS TO THE POLICE	4
LEGAL PROCEEDINGS	5
INSURANCE POLICIES AND RISK MANAGEMENT	6
CLINICAL AUDIT	7
PUTTING THINGS RIGHT REGULATIONS	8
SEAL	9
GIFTS & HOSPITALITY	10
DECLARATION OF INTERESTS	11
INFORMATICS AND THE DATA PROTECTION ACT	12
AUTHORISATION OF NEW DRUGS	13
AUTHORISATION OF RESEARCH PROJECTS	14
AUTHORISATION OF CLINICAL TRIALS	15
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	16
REVIEW OF FIRE PRECAUTIONS	17
HEALTH & SAFETY	18
MEDICINES INSPECTORATE REGULATIONS	19
ENVIRONMENTAL REGULATIONS	20
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	21
COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO	22
EMERGENCY PLANNING	23
STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION	24
APPOINTMENT OF MEDICAL & DENTAL CONSULTANT POSTS	25
HUMAN TISSUE ACT 2004	26
IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2017 [IR(ME)R]	27
NURSE STAFFING LEVELS (WALES) ACT 2016	28
WELSH LANGUAGE STANDARD REPORTING	29
CONTROLLED DRUGS ACCOUNTABLE OFFICER	30
UPHOLDING PROFESSIONAL STANDARDS IN WALES (UPSW)	31

Board Member Responsible (Tiers 2, 3 or 4): in line with the Standing Orders, delegated approval to the relevant Board Member, Board Committee, Executive Director or Executive Team member. Where there is more than one Executive Director Team member named the applicable responsibility is in relation to their individual service area.

Specific Delegation Where Applicable: The intention is to delegate to the Operational Divisions wherever possible, however some Matters are either delegated through a Director, Associate or Assistant then to the Operational Division, or they are not delegated beyond this secondary level. This column sets out the delegation flow where relevant. Where there is more than one 'Accountable Lead' named the applicable responsibility is in relation to their individual service area.

Operational Responsibility (Tier 4): – where Matters are delegated to the Operational Divisions, the generic term “Service Director” has been used to identify the Accountable Lead, for example IHC Director, Director of Mental Health, Cancer, and Support Functions. It is also recognised that these Matters are delegated within Health Board Policy and where relevant are directly supported by Finance, People Services and other Support Functions.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
1. Meetings			
a) Calling meetings of the LHB	Chair	Director of Corporate Governance	Not Delegated
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Not Delegated	Not Delegated
2. Personnel			
All Matters locally supported by CFO / FD / People			
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Executive Director People and OD	Supported by Members of the Executive Committee	Service Director
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director People and OD	Associate Director People Services	Not delegated
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director People and OD	Deputy Director Workforce & OD / Associate Director of People Services (IHC / PAN BCU / Support Services)	Service Director
d) Travel & subsistence expenses			
Authority to authorise travel & subsistence expenses	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Maintenance of a list of managers authorised to sign payroll and travel expense documentation (and via e-expense systems)	Executive Director People and OD	Deputy Director of Workforce & OD	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
e) Leave			
Approval of annual leave in accordance with LHB policy	Executive Director People and OD	Direct to Operational Services	Service Director
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Compassionate leave	Executive Director People and OD	Direct to Operational Services	Service Director
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director People and OD	Direct to Operational Services	Service Director
Leave without pay	Executive Director People and OD	Direct to Operational Services	(Tier 4)
Medical Staff Leave of Absence – paid and unpaid	Executive Director People and OD	Direct to Operational Services	Service Director
Consultants Special Leave	Executive Medical Director	Direct to Operational Services	(Tier 4)
Time off in lieu	Executive Director People and OD	Direct to Operational Services	Service Director
Maternity / Paternity Leave – paid and unpaid	Executive Director People and OD	Direct to Operational Services	(Tier 4)
f) Annualised hours/flexible working hours system-maintenance of adequate records	Executive Director People and OD	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
g) Sick Leave			
Extension of sick leave on half pay up to three months	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Not delegated
Return to work part-time on full pay to assist recovery	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Service Director (Tier 4)
Extension of sick leave on full pay	Executive Director People and OD	Direct to Operational Services in conjunction with Associate Director of People Services	Not delegated
h) Study Leave			
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director People and OD	Direct to Operational Services	Service Director
Medical staff study leave (UK)	Executive Medical Director / Executive Director People and OD	Direct to Operational Services	(Tier 4)
Consultant Medical Staff Leave (UK)	Executive Medical Director	Direct to Operational Services	Service Director
All Medical and non-Medical Clinical Staff study leave outside the UK (as per relevant professional lead)	Executive Medical Director / Executive Director of Nursing & Midwifery / Executive Director of Therapies & Health Science / Chief Operating Officer	Direct to Operational Services	(Tier 4)
All other study leave (UK)	Executive Director People and OD	Direct to Operational Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
i) Removal Expenses			
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Executive Director People and OD	Direct to Operational Services → In accordance with BCUHB policy / approval from the Executive Director People and OD	Service Director
j) Respect & Resolution Procedure	Executive Director People and OD	Direct to Operational Services	(Tier 4)
k) Professional Misconduct/Competence-Medical and Dental Staff	Executive Medical Director / Executive Director People and OD	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
l) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
m) Formal actions as required under The Performers List	Chief Executive	Executive Medical Director supported Executive Director People and OD and Chief Operating Officer	Not Delegated to Operational Divisions, cover for Executive Medical Director provided through the Deputy Responsible Officer or Deputy Medical Director
n) Requests for new posts to be authorised as car users	Executive Director of Finance	Direct to Operational Services	Service Director
o) Renewal of Fixed Term Contract	Executive Director People and OD	Direct to Operational Services	(Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director People and OD	Associate Director of People Services	Service Director for local implementation: Ultimate Approval is via NHS Pensions Agency
q) Disciplinary Procedure (excluding Executive Directors)	Executive Director People and OD	Executive Directors and Members of the Executive Committee	Service Director (Tier 4)
3. Engagement of Staff Not On the Establishment			
a) Non clinical Consultancy Staff	Executive Director of Finance	Supported by Executive Team	Service Director
b) Medical Locum staff	Executive Medical Director	Direct to Operational Services	(Tier 4)
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director (Tier 4)
d) Booking of Bank Staff:			
Nursing	Executive Director of Nursing & Midwifery	Direct to Operational Services	Service Director (Tier 4)
Other Staffing Groups	Executive Director People and OD	Direct to Operational Services	Service Director (Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
4. Procedure to follow after reporting of incidents to the Police (refer to Standing Operating Process in relation to reporting requirement to Security Advisors)			
a) Where a criminal offence is suspected	Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services	Service Director for implementation and compliance
b) Criminal offence of a sexual or violent nature	Ex Executive Director of People and OD Executive Director of Workforce & OD	Direct to Operational Services	Service Director for implementation and compliance
c) Arson or theft	Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services	Service Director for implementation and compliance
d) Other	Chief Executive and Executive Director of Finance and Executive Director of People and OD	Direct to Operational Services → dependent upon the nature of the suspected offence	Service Director for implementation and compliance
5. Legal Proceedings			
a) Engagement of the LHB's Legal Services	Director of Corporate Governance	Deputy Director for Legal Services	List of officers authorised to instruct Legal Services will be detailed in the Legal Services Policy Out of Hours approval via Gold On-Call.

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Approve and sign all documents on behalf of the LHB which will be necessary in legal proceedings	Director of Corporate Governance	Any Director of the Board or the Deputy Director for Legal Services provided such approval is in accordance with advice from a regulated legal professional – all contrary decisions are reserved for the Chief Executive	Not Delegated
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive	Not Delegated
6. Insurance Policies (incorporating Risk Management)			
Insurance Policies (incorporating Risk Management)	Chief Executive	Executive Director of Finance and Director of Corporate Governance	Not Delegated except for matters relating to the Welsh Risk Pool where the Deputy Director for Legal Services may act
7. Clinical Audit			
Clinical Audit	Chief Executive	Executive Medical Director	Service Director (Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
8. Putting Things Right Regulations (in line with WRP Policy & Guidance)			
a) Overall responsibility for ensuring that all concerns (as defined in PTR Regulations) are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery / Director of Corporate Governance (for redress, personal injury claims and clinical negligence claims)	Service Director Patient Safety Team, and Patient and Carer Experience/Complaints Team/Legal Services Team for implementation
b) Responsibility for ensuring complaints are investigated thoroughly, and learning is embedded.	Chief Executive	Executive Director of Nursing & Midwifery	Service Director and Patient and Carer Experience/Complaints Team for implementation
c) Medico – Legal Matters - Co-ordination of their management (including redress, personal injury claims and clinical negligence claims)	Director of Corporate Governance	Deputy Director for Legal Services	Legal Services Team
9. Seal			
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Governance	Not Delegated
b) Attestation of seal in accordance with Standing Orders	Chief Executive and Chair	Director of Corporate Governance	Not Delegated
c) Signing and sealing documents in accordance with Standing Orders	Chief Executive and Chair	Director of Corporate Governance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
10. Gifts and Hospitality			
a) Keeping of gifts and hospitality register	Chief Executive	Director of Corporate Governance	Service Director for implementation and compliance
11. Declaration of Interests			
a) Maintaining a register of interests	Chief Executive	Director of Corporate Governance	Service Director for implementation and compliance
12. Informatics and the Data Protection Act			
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Chief Digital and Information Officer	Data Protection Officer
b) Responsibility for Informatics policy and strategy	Chief Executive	Chief Digital and Information Officer	Service Director
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Chief Executive	Chief Digital and Information Officer	(Tier 4)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
13. Authorisation of New Drugs			
Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies (Clinical approval via NICE Implementation Group and Drugs and Therapy Group for onward financial approval by Executive Committee)	Not Delegated
14. Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)			
Authorisation of Research Projects (individuals responsible for their own declaration of interest to UKPI and BCUHB)	Executive Medical Director	Director of Research & Development	Service Director (Tier 4)
15. Authorisation of Clinical Trials			
Authorisation of Clinical Trials	Chief Executive	Executive Medical Director	Service Director (Tier 4)
16. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice			
	Chief Executive	Executive Director of Public Health	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
17. Review of Fire Precautions			
Review of Fire Precautions	Chief Executive	Director of Environment and Estates	Not Delegated
18. Health & Safety			
Review of all statutory compliance legislation and Health and Safety requirements (including associated mandatory staff awareness training).	Chief Executive	Director of Environment and Estates	Not Delegated
19. Medicines Inspectorate Regulations			
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist	Service Director via Head of Medicines Management
20. Environmental Regulations			
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Director of Estates and Environment	Not Delegated
21. Cost/Notional Rent/Third Party Developer/Improvement Grants			
All Matters locally supported by CFO / FD			
Approval of all schedules of payments	Chief Executive	Chief Operating Officer	Service Director (Tier 4)
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU Strategy	Chief Executive	Chief Operating Officer and Director of Estates and Environment	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
22. Compliance Lead Roles:			
a) Caldicott Guardian	Chief Executive	Executive Medical Director	Deputy Medical Director
b) Data Protection Officer	Chief Executive	Data Protection Officer	Head of Information Governance
c) Senior Information Risk Owner	Chief Executive	Chief Digital Information Officer	Not Delegated
23. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)			
Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Public Health	Head of Emergency Preparedness Response and Resilience
24. Statutory compliance with respective Legislation			
Individual Board Members responsible for the implementation of respective legislation	Chief Executive	Director of Corporate Governance	Service Director for implementation
25. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.			
Appointment of all Medical and Dental Consultant posts	Board	Chair of ACC's and reported to the People and Culture Committee	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
26. Human Tissue Act 2004			
Compliance with the Human Tissues Act	Chief Executive	Executive Medical Director	Service Director for implementation
27. Ionising Radiation (Medical Exposure) Regulations 2017			
Compliance Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Allied Health Professionals and Health Science / Executive Medical Director	Service Director for implementation
28. Nurse Staffing Levels Act (Wales) 2016			
Compliance with Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery	Service Director for implementation
29. Welsh Language Standard Reporting			
Compliance with the Welsh Language Standards	Chief Executive	Executive Director of Allied Health Professionals and Health Science	Service Director for implementation
30. Controlled Drugs Accountable Officer			
Controlled Drugs Accountable Officer	Chief Executive	Chief Pharmacist	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
31. Upholding Professional Standards in Wales (UPSW)			
Responsible Officer	Executive Medical Director (SRO)	Deputy Medical Director (Deputy Responsible Officer)	Service Director for implementation
Appointing a Designated Board Member	Health Board Chair	Remuneration Committee	Not Delegated

SCHEME OF DELEGATION LINKED TO STANDING FINANCIAL INSTRUCTIONS

Introduction

This Schedule of additional delegations identifies those specific areas within the Standing Financial Instructions which require additional delegations from the Board, Chief Executive and the Executive Director of Finance and other Officers.

This Schedule should not be read in isolation and needs to be used alongside the full set of Standing Financial Instructions at Schedule 3 of Standing Orders.

The following principles will apply:

- i. Financial limits are at the discretion of the Board;
- ii. Each cost centre must have a single approved budget holder who is accountable for ensuring budgets do not overspend and that expenditure is committed within the Health Board's delegated approved levels as detailed in the budget holder signed Accountability Agreement;
- iii. In an officer's absence, financial limits can be delegated in part or in total either generally or for specific items;
- iv. Directors can assign delegated budget holders with approval limits up to £150k at their discretion
- v. These limits apply to requisition authorisation, which is where the control lies;
- vi. In exceptional circumstances, the Chair may have delegated authority on behalf of the Board, and the use of the delegated authority to the Chair must be included in the minutes of the next meeting of the Board;
- vii. Each Director has the responsibility of cascading the delegation within their area and ensuring that authorised signatories are in place but will remain ultimately accountable for their budget. It may be appropriate for some areas of expenditure to be notified to the Board even if they are within the budget holder's limits;
- viii. The delegations and approval levels apply to all financial activity of the Health Board, irrespective of the income source relating to the expenditure, for example, any ringfenced income and expenditure must still follow this Scheme of Delegation.

Responsibility for authorising the purchase of goods and services (including capital schemes), Service Level Agreements and Memorandum of Understandings, with non-NHS bodies are subject to the maximum delegated levels of authority and also other approval requirements and delegations as detailed in the Scheme of Delegation, as follows:

Financial Delegations

Tier	Authority Delegated to Financial delegation	Financial delegation Authority Delegated to	Oracle Approvers
0	Board	Above £1,000,000	Chief Executive following approval by Board and Welsh Government
1	Chief Executive	Up to £1,000,000	Chief Executive
2	Executive Director of Finance Deputy Chief Executive	Up to £500,000	Executive Director of Finance Deputy Chief Executive
3	Executive Directors	Up to £300,000	Executive Directors
4	Senior Officers (<i>not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Communications and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment</i>)	Up to £250,000	Senior Officers (<i>not included in tier 3 including Finance Director: Commissioning and Financial Planning; Director of Corporate Governance; Director of Communications and Engagement; Chief Digital and Information Officer; and Director of Estates and Environment</i>)
5	Assistant / Associate / Deputy Directors or Heads of Service	Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service
6	Service Contract Manager or Head of Operations	Up to £50,000	Service Contract Manager or Head of Operations

7	Service Lead or Site / General Manager	Up to £30,000	Service Lead or Site / General Manager
8	Nominated Budget Holder for specific cost centres	Up to £25,000	Nominated Budget Holder for specific cost centres

1. General Requirements, Overriding Financial Instructions and Financial Provisions and Obligations

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
1A	Health Board's must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have the effect as if incorporated in the Standing Orders (SOs).	1.1.1	Board	Director of Corporate Governance working with the Executive Director of Finance to ensure SFIs are in place and agreed by the full Board.
1B	All financial policies ~~procedures~~ must be approved by the Executive Director of Finance and Audit Committee.	1.1.3	Executive Director of Finance Audit Committee	No further delegation
1C	Should any difficulties arise in the interpretation of any of the SFIs then advice of the Director of Corporate Governance and Executive Director of Finance should be sought before acting. The users of SFIs should also be familiar with the provisions of the health boards SOs.	1.1.4	All Board Members and Officers of the Health Board	Director of Corporate Governance is responsible for ensuring all Board members are aware of this requirement Executive Directors are responsible for ensuring that their teams are aware of this requirement.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
1D	Full details of any non-compliance with SFIs and explanation of the reasons for non-compliance to be reported to the Executive Director of Finance and Director of Corporate Governance.	1.2.1	All Board Members and Officers of the Health Board	Director of Corporate Governance is responsible for ensuring all Board members are aware of this requirement Members of the Executive Committee are responsible for ensuring that their teams are aware of this requirement.
1E	Executive Director of Finance and Director of Corporate Governance to refer any matters of non-compliance to the Audit Committee to formally consider the matter. Audit Committee to make proposals to the Board on any action to be taken.	1.2.1	Executive Director of Finance/ Director of Corporate Governance Audit Committee	Finance Director: Commissioning and Financial Planning in the absence of the Executive Director of Finance <u>and</u> the Head of Corporate Governance in the absence of the Director of Corporate Governance.
1F	The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer must ensure that the health board meets its statutory obligation to perform its functions within the available financial resources.	1.3.1	Board Chief Executive specifically	No further delegation. Guidance on the responsibility of budget holders is set out later in this document.

2. Responsibilities and delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2A	The Board exercises financial supervision and control by: a) Formulating the Medium-Term Financial Plan (MTFP) as part of the Integrated Medium-Term Plan (IMTP); b) Requiring the submission and approval of budgets within approved allocations/overall funding c) Defining and approving essential features in respect of important financial policies, systems and controls (including the need to obtain value for money and sustainability); and d) Defining specific responsibilities placed on Board members and Health Board officers, and Health Board committees and Advisory Groups as indicated in the 'Scheme of delegation' document.	2.1.1	Board	Coordination and management of the development of the IMTP - Executive Director of Transformation, Strategic Planning & Commissioning Coordination and development of the MTFP – Executive Director of Finance
2B	Responsibility for the health board's system of internal control.	2.2.2	Chief Executive	Executive Directors are responsible for ensuring adequate systems of internal control are in place across their areas of responsibility.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2C	It is the duty of the Chief Executive to ensure that Board members, health board officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs	2.2.3	Chief Executive	Director of Corporate Governance and Executive Director of Finance are responsible for ensuring all Board members understand their responsibilities. Executive Directors are responsible for ensuring that their teams understand their responsibilities.
2D	The Executive Director of Finance is responsible for: a) Implementing the health board's financial policies and for coordinating any corrective action necessary to further these policies; b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;	2.3.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) Ensuring that sufficient records are maintained to show and explain the health board's transactions, in order to disclose, with reasonable accuracy, the financial position of the health board at any time; and d) Without prejudice to any other functions of the health board, Board members and health board officers, the duties of the Executive Director of Finance include: (i) the provision of financial advice to other Board members and health board officers, and health board committees and Advisory Groups, (ii) the design, implementation and supervision of systems of internal financial control, and (iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the health board may require for the purpose of carrying out its statutory duties.			Finance Director: Commissioning and Financial Planning No further delegation
2E	The Executive Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.	2.3.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
2F	All Board members and health board officers, and health board Committees and Advisory Groups, severally and collectively, are responsible for: a) The security of the property of the health board; b) Avoiding loss; c) Exercising economy, efficiency and sustainability in the use of resources; and d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.	2.4.1	All Board members, officers, Committees and Advisory Groups	No further delegation
2G	Any contractor or employee of a contractor who is empowered by the health board to commit the health board to expenditure or who is authorised to obtain income shall be covered by the SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.	2.5.1	Chief Executive	Executive Directors are responsible for ensuring this is understood by contractors working in their area.

3. Audit, Fraud and Corruption, and Security Management

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3A	In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference.	3.1.1	Board	No further delegation. Director of Corporate Governance will support the establishment of the Committee and ensure clear terms of reference are in place.
3B	The Audit Committee will follow the guidance set out in the NHS Wales Audit Committee Handbook. <i>Note: if new or revised guidance is issued in addition to / replacement of the Handbook, the Committee should follow the revised guidance.</i>	3.1.1	Chair of Audit Committee	No further delegation. Chair of Audit Committee to be supported by Director of Corporate Governance.
3C	Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective Internal Audit function.	3.2.1 (a)	Chief Executive	Director of Corporate Governance
3D	Ensuring that the Internal Audit function meets the required standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer.	3.2.1 (b)	Chief Executive	Chief Executive to be supported by Director of Corporate Governance Head of Internal Audit

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3E	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption	3.2.1 (c)	Chief Executive	Director of Corporate Governance and Executive Director of Finance or Executive Director of People Services and Organisational Development
3F	Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board.	3.2.1 (d)	Chief Executive	Head of Internal Audit and Director of Corporate Governance
3G	The health board's Audit Committee must ensure that a cost-effective external audit service is delivered.	3.4.1	Audit Committee	Director of Corporate Governance and Executive Director of Finance to support the Audit Committee.
3H	The Audit Committee should consider the annual audit plan prepared by the external auditors and the associated fees. The Audit Committee should consider material changes to the annual audit plan.	3.4.3	Audit Committee	No further delegation. Director of Corporate Governance to ensure review scheduled in to the Committee's work programme
3I	The Auditor General's representative should be invited to attend every Audit Committee.	3.4.4	Director of Corporate Governance	

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3J	The health board will provide the Auditor General and his representatives with whatever facilities are necessary to facilities audits, including accommodation and access to IT facilities.	3.4.7	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
3K	The Chief Executive and Executive Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.	3.5.1	Chief Executive and Executive Director of Finance	No further delegation The Executive Director of Finance will be responsible for regular liaison with Counter Fraud Services
3L	The health board shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.	3.5.2	Board	Executive Director of Finance to put arrangements in place. Audit Committee to review adequacy of arrangements.
3M	Local Counter Fraud Specialist to provide a written report to the Executive Director of Finance and Audit Committee at least annually, on counter fraud work within the health board	3.5.4	Local Counter Fraud Specialist	No further delegation. Director of Corporate Governance to ensure report scheduled in to the work programme of the Audit Committee.

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
3N	The health board must participate in the annual National Fraud Initiative. The Audit Committee should consider the health board's participation in additional dataset matching in order to support the detection of fraud across the whole public sector.	3.5.5	Executive Director of Finance Audit Committee	Director of Corporate Governance to ensure review scheduled in to the work programme of the Audit Committee.
3O	The Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.	3.6.1	Chief Executive	Executive Director of Finance, with support from relevant Directors.
3P	The Chief Executive has overall responsibility for controlling and co-ordinating security.	3.6.2	Chief Executive	Executive Director of Finance, with support from relevant Directors.

4. Financial Duties

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
4A	The Executive Director of Finance of the Health Board will: a) Prior to the start of each financial year, submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution, including any sums to be held in reserve; b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements; c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and d) Regularly update the Board on significant changes to the initial allocation and the application of such funds.	4.2.4	Executive Director of Finance	No further delegation
4B	The Chief Executive has overall executive responsibility for the health board's activities and is responsible to the Board for ensuring that it meets its financial duty to breakeven.	4.2.5	Chief Executive	Executive Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
4C	The Chief Executive will compile and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan.	4.3.7	Chief Executive	Executive Director of Transformation and Strategic Planning
4D	The Board will: a) Approve the Integrated Medium-Term Plan (IMTP) prior to the beginning of the financial year of implementation. b) Approve a balanced Medium Term Financial Plan (MTFP) as part of the Integrated Medium-Term Plan, which meets all probity and value for money requirements; and c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the health board plan is not in place or in balance.	4.3.8	Board	Performance, Finance and Information Governance Committee and the Planning, Population and Health Partnership Committee will scrutinise the draft IMTP and MTFP and make recommendations to the Board.
4E	The Board approved Integrated Medium-Term Plan will be submitted to the Welsh Government in line with the requirements of the Integrated Planning Framework.	4.3.9	Board	Chief Executive on Board's behalf

5. Financial Management and Budgetary Control

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5A	Prior to the start of the financial year the Executive Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board.	5.1.1	Executive Director of Finance	No further delegation
5B	Approval and Delegation of budgets	5.1.1	Board	No further delegation
5Bi	Approval of annual detailed budget for Directorates within budget approved by Board	Local	Executive and Associate Directors	No further delegation
5Bii	Delegation of budgets to budget holders including ensuring the appropriate documentation is completed and returned to the Finance Directorate	Local	Executive and Associate Directors	No further delegation
5Biii	Authorisation of expenditure above budget	Local	Chief Executive	Reported to Audit Committee See Table 5B (1) below
5C	The Chief Executive may delegate, via the Executive Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with Section 33 of the NHS (Wales) Act 2006 (C.42). This delegation must be in writing, in the form of a letter	5.2.1	Chief Executive	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	of accountability, and be accompanied by a clear definition of: a) The amount of the budget; b) The purpose(s) of each budget heading; c) Individual or committee responsibilities; d) Arrangements during periods of absence; e) Authority to exercise virement; f) Achievement of planned levels of service; and g) The provision of regular reports.			
5D	Delegation to include the authority to exercise virement and budget transfers	5.2.1	Chief Executive	Executive Director of Finance See Table 5D (1) below
5E	The Chief Executive, Executive Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.	5.2.2	Chief Executive	Executive Director of Finance Budget Holders
5F	Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Finance.	5.2.4	Chief Executive <i>[advised by Executive Director of Finance]</i>	No further delegation
5G	All budget holders must provide information as required by the Executive Director of Finance to enable budgets to be compiled and managed appropriately.	5.2.5	Budget Holders	No further delegation
5H	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	5.2.6	Budget Holders	See Table 5H (1) below

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5I	The Executive Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.	5.2.7	Executive Director of Finance	Chief Finance Officers

Table 5B (1) - Authority to commit resources above expenditure baselines set within delegated budgets

Ref	Revenue Business Case Value (Total Value)	Approved by:
1	Up to £0.25m	Chief Executive (or Deputy Chief Executive) and Executive Director of Finance All approvals retrospectively reported to Executive Committee
2	Above £0.25m, up to £0.5m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee
3	Above £0.5m, up to £1.0m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee
4	Above £1.0m	Relevant Executive Director and Executive Director of Finance and then approval by Executive Committee plus the Performance, Finance & Information Governance Committee plus approval by Board and Welsh

	Government

Table 5D (1) -Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to Revenue budgets & <i>vice versa</i>
Within own budget* a department	Budget manager*	Executive Director of Finance in liaison with Welsh Government
Between Area Teams, Hospital Teams or Corporate Departments*	Relevant Tier 3 or 4 Officer(s)*	
Between Area Teams, Hospital Teams or Corporate Departments Above Tier 3 or 4 Officer's delegated limit and up to £0.5m	Relevant Tier 3 or 4 Officer(s) and the Finance Director – Commissioning and Financial Planning	
Between Area Teams, Hospital Teams or Corporate Departments: Above £0.5m and up to £1.0m	Relevant Tier 3 or 4 Officer(s) and the Executive Director of Finance or Chief Executive	
Between Area Teams, Hospital Teams or Corporate Departments Above £1.0m	Board	
* Virement requests for increases in STAT (WTE)	*Also require approval of Finance Director: Commissioning and Financial Planning	
Budget transfers between Reserves and delegated budgets	Finance Director: Commissioning and Financial Planning	
Notification of virement to Directorate of Finance to ensure budget updated	Individual authorising the virement	

Table 5H (1)

Delegated Matter	Delegated to:	Agreed by:
Delegation of the management of defined Revenue budgets to budget holders: i. Revenue budgets for Clinical Directorates ii. Revenue budgets for Corporate Directorates iii. Reserves	i. Budget Holders ii. Budget Holders iii. Finance Director: Commissioning and Financial Planning	i. Executive Directors ii. Executive Directors iii. Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
5J	Monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to the Board as soon as they come to light and the Board shall be	5.3.1	Executive Director of Finance	No further Delegation [Finance Director: Commissioning and Financial Planning <i>supports preparation</i>]

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	advised on any action to be taken in respect of such variances.			
5K	Devise and maintain systems of financial management, performance reporting and budgetary control.	5.3.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
5L	Each Budget Holder is responsible for ensuring that: a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation; b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement; c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.	5.3.4	Budget Holders	No further delegation
5M	The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the	5.3.5	Chief Executive	Executive Director of Finance with Executive and Associate Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	requirements of the Medium-Term Financial Plans.			
5N	All monitoring returns must be supported by a detailed commentary signed by the Executive Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.	5.5.2	Chief Executive and Executive Director of Finance	No further delegation <i>[if not available these are delegated to their deputies]</i>
5O	All information made available to the Welsh Ministers must be made available to the Board.	5.5.3	Chief Executive and Executive Director of Finance	Director of Corporate Governance

6. Annual Accounts and Reports

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
6A	The Board must approve the health board's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.	6.1	Board	No further delegation The Audit Committee will provide advice and make recommendations.
6B	The Chair and Chief Executive have responsibility for signing the accounts on behalf of the health board. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.	6.2	Chair and Chief Executive Chief Executive	No further delegation No further delegation
6C	Ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers and consistent with Financial Reporting Manual and International Financial Reporting Standards.	6.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
6D	The health board's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.	6.4	Board	No further delegation <i>[Director of Corporate Governance responsible for ensuring arrangements for a public meeting are made]</i>
6E	The health board will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The document will comply with the Welsh Government's Manual for Accounts.	6.5	Board	Director of Corporate Governance to prepare draft for Board consideration.

7. Banking arrangements

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
7A	The Executive Director of Finance is responsible for managing the Health Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. Health boards are required to use the Government Banking Service (GBS) for its banking services.	7.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7B	Approval of banking arrangements	7.1.2	Board	Audit Committee
7C	The Executive Director of Finance is responsible for: a) Establishing bank accounts; b) Establishing additional commercial accounts (exceptionally); c) Establishing separate bank accounts for the health board's non-exchequer funds; d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; e) ensuring accounts are not overdrawn except in exceptional and planned situations; f) Reporting to the Board all arrangements made with the	7.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	health board's bankers for accounts to be overdrawn; g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.			
7D	All accounts should be held in the name of the health board. No officer other than the Executive Director of Finance shall open any account in the name of the health board or for the purposes of furthering health board activities	7.2.2	Executive Director of Finance	No further delegation
7E	The Executive Director of Finance will prepare detailed instructions on the operation of bank accounts which must include: i) The conditions under which bank accounts are to be operated; ii) Those authorised to sign cheques or other orders drawn on the health board's accounts; iii) Authorised signatories are identified with sufficient seniority, and in the case of e-banking approvers, together with an appropriate approval hierarchy.	7.3.1	Executive Director of Finance	i) Finance Director: Commissioning and Financial Planning ii) See Table 7E (1) below
7F	The Executive Director of Finance must advise the Health Board's bankers in writing of the conditions under which each account will be operated.	7.3.2	Executive Director of Finance	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
7G	The Executive Director of Finance shall approve security procedures for any cheques issued without a hand-written signature	7.3.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7H	The Executive Director of Finance will review banking arrangements of the health board at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money.	7.4.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
7I	The results of the review should be reported to the Audit Committee.	7.4.1	Executive Director of Finance	Director of Corporate Governance to ensure that such reports go to the Committee.

Table 7E (1)

Day to day operation of bank accounts: i. maintain list of approved signatories for manual payments ii. approval to authorise automated payments: • accounts payable* • payroll • primary care contractors iii. maintain list of bankline users and authorisers for internet banking transactions	i. Finance Director: Commissioning and Financial Planning ii. NHS Wales Shared Services Partnership iii. Finance Director: Commissioning and Financial Planning

***after confirmation from Head of Financial Control that sufficient funds are available in the bank account**

8. Cash, cheques, Payment Cards and other negotiable instruments

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
8A	The Executive Director of Finance is responsible for: a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; b) Ordering and securely controlling any such stationery with management responsibility given to a duly designated employee; c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; d) establishing systems and procedures for handling cash and negotiable securities on behalf of the health board; e) Ensuring effective control systems are in place for the use of payment cards; f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.	8.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
8B	Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Finance	8.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

9. Income, fees and charges

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
9A	Designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.	9.2.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9B	Ensuring that systems are in place for the prompt banking of all monies received.	9.2.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9C	Approving and regularly reviewing the level of all fees and charges, other than those determined by the Welsh Ministers or by statute (<i>Private patients, overseas visitors, income generation and other related services</i>)	9.3.1	Executive Director of Finance	Head of Healthcare Contracting - Finance
9D	All officers must inform the Executive Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.	9.3.2	All Officers of the Health Board	Executive Directors are responsible for ensuring that all their teams are aware of this requirement. Table 9D (1) sets out details of delegations related to fees and charges.

Table 9D (1)

Fees and Charges:	Authority Delegated to
Service Level Agreements / Contracts with other NHS bodies i. Up to £30,000 ii. Up to £50,000 iii. Up to £150,000 iv. Up to £250,000 v. Between £250,000 and £5 million vi. Between £5 million and £10 million vii. Over £10 million	~~Agreement to provide services with an annual income value up to £250,000 must be provided by the Chief Operating Officer and Executive Director of Finance.~~ Above £~~300~~250,000 must be approved by Executive Committee. SLA / Contracts to be signed in accordance: i. Specific Budget Holders as per operational Schemes of Delegation ii. Service Contract Manager iii. Director / Head of Service iv. Relevant IHC / Service Director v. Relevant Executive Director and Finance Director: Commissioning and Financial Planning vi. Executive Director of Finance or Chief Executive vii. Chief Executive (following approval by the Executive Committee and the Board)
Grant Funding Agreements Agreement to receive a grant with a total income value:	

i. up to £75,000 ii. up to £250,000 iii. up to £500,000 iv. up to £1 million v. over £1 million	i. Assistant Directors Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Board and Welsh Government)
Healthcare Agreements / Contracts with Private and 3rd Sector Organisations Authority to sign Agreement to provide services with a total income value over life of contract (following relevant governance approvals): i. up to £75,000 ii. up to £250,000 iii. up to £500,000 iv. up to £1 million v. over £1 million	i. Assistant / Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Executive Committee and the Board)
Healthcare Agreements / Contracts with Local Authorities and Public Bodies Authority to sign Agreement to provide services with a total income value over life of contract (following relevant governance approvals):	

i. up to £75,000 ii. up to £250,000 iii. up to £1 million iv. up to £5 million v. over £5 million	i. Assistant / Associate / Deputy Directors (Tier 5) ii. Service Directors (Tier 4) iii. An Executive Director and Finance Director: Commissioning and Financial Planning (following approval by the Executive Committee) iv. Executive Director of Finance or Chief Executive (following approval by the Executive Committee) v. Chief Executive (following approval by the Executive Committee and the Board)
Individual NHS patient treatment charges outside of Agreements / Contracts Agreement to provide treatment	Executive Director of Finance
Private Patients and overseas patients without reciprocal agreements i. pricing policy and price structure ii. payment policy, including use of deposits, income guarantees, arrangements with insurance companies	Executive Director of Finance with relevant Director
Commercial sponsorship offers (including funding contributions for staff & non staff costs) Agreement to receive commercial sponsorship or funding (in accordance with the relevant Health Board Policy)	Chief Executive or Executive Director of Finance

Commercial and non-commercial research projects and trials Agreement to receive funding: i. up to £50,000 ii. £50,000 to £100,000 iii. Over £100,000	i. Executive Medical Director and Director of Finance – Commissioning & Financial Planning ii. Executive Medical Director and Executive Director of Finance iii. Executive Director of Finance (following approval by Executive Committee)

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
9E	The Executive Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place.	9.4.3	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
9F	Ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.	9.4.6	Chief Executive & Executive Director of Finance	Finance Director: Commissioning and Financial Planning

10. Non-Pay expenditure

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10A	The Chief Executive will approve the level of non-pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the health board's scheme of delegation	10.1.2	Chief Executive	Executive and Service Directors See Table Below for Oracle and non-Oracle requisitions

ALL DIRECTORATES MUST HAVE A LOCAL / OPERATIONAL SCHEME OF DELEGATION LINKING ACTIVITIES TO THE MAXIMUM DELEGATED LIMITS SET OUT BELOW AT A GRANULAR LEVEL OF APPLICATION WITHIN THEIR SERVICE AREA.

All Financial Limits shown below are inclusive of VAT irrespective of recovery arrangements

ORACLE REQUISITIONS	Authority Delegated to
Up to £25,000	Nominated Budget Holder for specific cost centres
Up to £30,000	Service Lead or Site / General Manager
Up to £50,000	Service Contract Manager or Head of Operations

ORACLE REQUISITIONS	Authority Delegated to
Up to £150,000	Assistant / Associate / Deputy Directors or Heads of Service
Up to £250,000	Service Director including Finance Director: Commissioning and Financial Planning
Up to £300,000	Executive Director
Up to £500,000	Executive Director of Finance Deputy Chief Executive
Up to £1 million	Chief Executive
Above £1 million	Chief Executive following approval by the Executive Committee, Board and Welsh Government

Expenditure commitments made outside of the ORACLE requisition process		Authority Delegated to
Contracts for HealthCare Services	See Section 12	See Section 12
Non-contracted activity for Healthcare Services	i. Up to £15,000 ii. Up to £30,000	i. Senior Finance Manager – Healthcare contracts ii. Principal Finance Manager –

	iii. Up to £75,000 iv. Up to £500,000 v. Above £500,000	Healthcare contracts iii. Head of Healthcare Contracting – Finance iv. Executive Director of Finance v. Chief Executive
Staff Travel and Subsistence		Line Managers
Pension Agency Invoices (Injury Benefit/Compensation)		Executive Director of Finance
Legal costs All claims and defence costs to be supported by formal legal advice	i. Up to £0.5 million ii. Up to £1 million iii. Above £1 million	i. Deputy Director of Legal Services ii. Director of Corporate Governance iii. Chief Executive (following Board approval unless otherwise delegated)
Legal Advice Requests	Chief Executive	Director of Corporate Governance (or Deputy Director of Legal Services) List of officers authorised to instruct approved Legal Services will be detailed in the Legal Services Policy

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10B	The Chief Executive will set out in the operational scheme of delegation and authorisation: a) The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and b) The maximum level of each requisition and the system for authorisation above that level.	10.1.3	Chief Executive	Executive and Service Directors
10C	The Executive Director of Finance will: a) Advise the Board regarding the thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs; b) Preparation of instructions and guidance on non-pay expenditure; c) Ensure systems of authorisation are in place; d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable; e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices; f) Be responsible for ensuring compliance with the Public Sector Payment policy; g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation,	10.2.1	Executive Director of Finance	See Table 10C (1) below for competition requirements for 'Goods and Non-Health Services Only' where there is no suitable procurement framework to source the required item(s)

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	guidance issued by the Welsh Ministers and SFIs; h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures			
10D	Compliance with the requirements below: a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged; b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement; c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made; d) goods have been duly received, examined and are in accordance with specification and order; e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct; f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or	10.3.1	Budget Holders	Executive Director of Finance to put arrangements to ensure compliance Executive Directors to ensure all budget holders within their Directorate are aware of the requirements

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	benefit to Board members or LHB officers, other than: (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, (ii) Conventional hospitality, such as lunches in the course of working visits; g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Finance on behalf of the Chief Executive; h) All goods, services, or works are ordered on official orders; i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds; j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase.			
10E	The Chief Executive and Executive Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director.	10.3.2	Chief Executive Executive Director of Finance	No further delegation
10F	Prepayments should be exceptional and are only permitted where either:	10.6.1	Executive Director of Finance	Executive Directors

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	▪ The financial advantages outweigh the disadvantages (i.e., cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%); ▪ It is the industry norm e.g., courses and conferences; There is specific Welsh Ministers' approval to do so e.g., voluntary services compact.			
10G	In exceptional circumstances prepayments can be made subject to: a) The appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Health Board if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments; b) The Executive Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);	10.6.2	Executive Director of Finance	Executive Directors
10H	The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.	10.6.2 part c)	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
10I	Approval for all external consultancy support (total contract value for duration of service) to be approved by Executive Committee. Approvals above £0.5m to also be approved by Board and above £1.0m to be approved by Welsh Government	Local	Executive Committee	As per Table below

Consultancy (Total contract value)	Contract to be signed by
Up to £0.25 million	An Executive Director and Finance Director: Commissioning and Financial Planning (2 to sign)
Up to £0.5 million	Executive Director of Finance or Deputy Chief Executive or Chief Executive
Up to £1 million	Chief Executive (following Board approval)
Above £1 million	Chief Executive (following approval by Board and Welsh Government)

Table 10C (1) 'Goods and Non-Health Services Only'

Goods/Services/Works (Whole Life Cost Contract Value)	Minimum Competition	Lead	Waivers, or exceptions to tender rules
Below £5,000	Evidence of value for money has been achieved	Budget owners	-
£5,000 to £24,999	Evidence of 3 written quotations	Procurement Services	Executive Director of Finance and NWSSP Procurement Services
£25,000 plus to the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 4 tenders received if available	Procurement Services	Single Tender Action authorised by Executive Director of Finance and Chief Executive
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Procurement Services	Single Tender Action prohibited
Contracts above £1m	Welsh Gov approval required (approval to be obtained at the planning stage)	Procurement Services	-

Notes:

Total value excluding VAT.

Subject to the existence of suitable suppliers

11. Procurement and contracting for goods and services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11A	The health board shall maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes.	11.2.1	Board <i>[Chief Executive is ultimately responsible]</i>	NWSSP Procurement Services
11B	The Procurement Act 2023 and associated subordinate instruments, the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments, and the Welsh Procurement Policy Notices are the key pieces of legislation which governs public sector procurement in the UK. All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with.	11.3.5	Executive Directors	Officers of the Health Board
11C	To help towards ensuring that the LHB is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the LHB shall, through Procurement Services, ensure that it shall have procedures that set out: a) requirements for, and exceptions to, formal competitive tendering ('Goods and Non-Health Services Only'); b) tendering processes including post tender discussions;	11.5.1	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance

	c) requirements and exceptions to obtaining quotations ('Goods and Non-Health Services Only'); d) evaluation and scoring methodologies; and e) approval of firms for providing goods and services. All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the Health Board's delegation arrangements and approval processes. *	11.5.2		
Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11D	The health board shall develop sustainable procurement solutions consistent with the Wellbeing of Future Generations (Wales) Act 2015 (the WBFG Act 2015). The health board is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains.	11.7.1 11.7.5	Board	No further delegation Executive Director of Transformation, Strategic Planning and Commissioning – to develop on behalf of Board
11E	The health board shall benchmark its performance in sustainable procurement against the Wellbeing of Future Generations (Wales) Act 2015 (WBFG Act 2015). For all contracts over £25,000, the health board shall take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).	11.7.6	Board	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11F	Minimum thresholds for quotes and competitive tendering arrangements for 'Goods and Non-Health Services' are to be complied with.	11.10.2	Executive Director of Finance	All Officers of the Health Board See Table 10(C)1
11G	In exceptional circumstances it may be necessary to secure goods/services/works from a single supplier. In these circumstances a Single Quote / Tender Application (Waiver) must be completed. The Executive Director of Finance must approve such applications up to £25,000; the Chief Executive or designated deputy, and Executive Director of Finance, are required to approve applications exceeding £25,000. This requirement for a Single Quote / Tender Application (Waiver) applies even if the award is a Single Supplier Direct Award under a 'procurement framework'.	11.13	Executive Director of Finance	No further delegation
11H	The relevant budget holder shall oversee and manage each contract on behalf of the health board so as to ensure that obligations on delivery of business and operational objectives, and achieving value for money, are met	11.16.1	Budget Holders	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
11I	The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the health board. In so doing, the health board's approved catalogue shall be used. Where a required item is not included within the catalogue, advice must be sought from procurement services.	11.18.1	Budget Holders	All individuals authorised to requisition items
11J	Where a required item is not included within the catalogue or on a framework contract, the budget manager shall request procurement services to undertake quotation / tendering exercises ('Goods and Non-Health Services Only') on their behalf.	11.18.2	Budget Holders	All individuals authorised to requisition items
11K	Approval to commence with competition via procurement services (for example, going to tender) must be received in line with this Scheme of Delegation prior to commencement of the competition.	Local	Budget Holders	All individuals authorised to requisition items
11L	All orders for goods ('Goods and Non-Health Services Only') and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.	11.18.3	Budget Holders	All individuals authorised to requisition items

****Current delegated limit for contracts before requiring Ministerial approval is £1m***

12. Health Care Agreements and Contracts for Health Care Services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
12A	The Chief Executive is responsible for ensuring the health board enters into suitable Health Care Agreements, or Individual Patient Commissioning Agreements, where appropriate for the provision of health care services from external providers. All agreements must be in accordance with the functions conferred on the Health Board by the Welsh Ministers.	12.1.1 12.1.3	Chief Executive	See Table 12A (1) – 12A (11) below
12A (i)	All Continuing Health Care Pre-Placement Agreements (PPA) are to be approved by the Chief Operating Officer Executive	Local	Chief Executive	~~No further delegation~~ Chief Operating Officer
12B	The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all Health Care Agreements with external providers.	12.3	Chief Executive	Executive Director of Finance Director of Corporate Governance to ensure that such reports are built in to work programmes.

Agreements for the purchase of services	Authority delegated to

		All new contracts or variations over £1 million to be retrospectively reported to Board.
	Agreements for the purchase of services	Authority delegated to
12A (3)	Healthcare Agreements / Contracts with non-NHS bodies (Private / 3rd Sector / Grants / Primary Care / Local Authorities)	~~Agreement to purchase services with a total contract value up to £250,000 over the life of contract must be provided approved by the Executive Director (Tier 3) and Executive Director of Finance (Tier 2)~~ Total contract value above £~~300~~250,000 must be approved by the Executive Committee. Following approval required above, the Agreement / Contract can be signed in accordance: i. Assistant Directors ii. Associate / Deputy Directors iii. Service Directors iv. Relevant Executive Director and Finance Director: Commissioning and Financial Planning v. Executive Director of Finance or Chief Executive vi. Chief Executive (following approval at Executive Committee, PFIG and the Board) vii. Chief Executive (following approval at Executive Committee, PFIG, Board and from Welsh Government) <i>Note: Welsh Government approval required in advance of contract planning</i>
	Agreements for the purchase of services	Authority delegated to

12A (4)	Individual Continuing Health Care (CHC) Placements/Packages - Authorisation of individual placements/packages following recommendation from the 'Local' CHC Panel. APPROVAL REQUIREMENTS EXCLUDES 'FAST TRACK' PROCESS AS PER THE WALES NATIONAL FRAMEWORK Agreement to purchase services with an annual value: ~~i. Up to £125,000~~ ~~ii. Between £125,000 and £200,000~~ iii. Between £200,000 and £1 million iv. Above £1 million	For placements above £200,000 per annum, recommendation is required from the Complex, Value for Money and High Risk CHC Panel prior to approval by the Executive Committee ~~i. Service Director and Chief Operating Officer~~ ~~ii. Chief Operating Officer and Executive Director of Finance~~ iii. Executive Director of Finance (following approval at Executive Committee) iv. Chief Executive (following approval at Executive Committee and Board)
12A (5)	Individual Patient Commissioning Agreements (for example, Mental Health Out of Area Placements) Agreement to purchase services with an annual value: i. Up to £125,000 ii. Between £125,000 and £250,000 iii. Between £250,000 and £1 million iv. Above £1 million	i. Service Director and Chief Operating Officer ii. Chief Operating Officer and Executive Director of Finance iii. Executive Director of Finance (following approval at Executive Committee) iv. Chief Executive (following approval at Executive Committee and Board)

	Agreements for the purchase of services	Authority delegated to
12A (6)	NHS Funded Nursing Care (FNC) i. Authorisation of individual placements/packages following recommendation from a Nurse Assessor ii. Agreement of changes to annual standard rates	i. IHC Director/Relevant Service Director (Tier 4) ii. Board (following recommendation from Executive Committee)
12A (7)	Individual Patient Funding Requests (IPFR) - Authorisation of individual agreements following recommendation from the IPFR Panel: i. Up to £125,000 ii. Between £125,000 and £299,000 iii. Between £300,000 and £1 million iv. Above £1 million	i. Chair and Vice-chair of BCUHB IPFR Panel ii. Chief Executive iii. Wales IPFR Panel iv. Welsh Government
12A (8)	Primary Care Contracts – General Medical Services (excluding enhanced services) i. Approval and Signing of the GMS contracts with practices ii. Variations to the Agreement iii. Payments under the contracts	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
12A (9)	Primary Care Contracts – General Medical Services (Enhanced services) i. Approval and Signing of agreements to provide Enhanced services ii. Variations to the Agreement iii. Payments under the Agreements	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP

	Agreements for the purchase of services	Authority delegated to
12A (10)	Primary Care Contracts – General Dental Services i. Approval and Signing of the GDS contracts with practices ii. Amendments to the Agreement iii. Payments under the contracts	i. Authority delegated as per Table 12A (3) ii. Authority delegated as per Table 12A (3) iii. Delegated to NWSSP
12A (11)	Primary Care Contracts – Pharmaceutical Services (including enhanced and advanced services) i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NWSSP ii. Authority delegated as per Table 12A (3)
12A (12)	Primary Care Contracts – General Ophthalmic Services i. Payments under the contracts or enhanced service agreements ii. Approval and signing of agreements to provide enhanced services	i. Delegated to NWSSP ii. Authority delegated as per Table 12A (3)
12A (13)	Providing services jointly with Local authorities under Section 32 and 33 of NHS (Wales) Act 2006. i. Approval and Signing of the pooled budget arrangements ii. Amendments to the Agreement	As per Table 12A (3) above

13. Grant funding

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
13A	Maintaining detailed policies and procedures for all aspects of grant funding- i.e., awarding of grants. Where appropriate these should comply with the Welsh Government's Code of Practice to funding the third sector.	13.2.1	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance
13B	Health Boards are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.	13.4.3	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance
13C	Health Boards are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s).	13.4.4	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance
Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the	Related responsibilities delegated to

			SFI sits with	
13D	The health board must enter into legally binding funding agreements	13.4.5	Board <i>[Chief Executive is ultimately responsible]</i>	Executive Director of Finance
	The health board is responsible for ensuring that all third-party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.	13.4.6		

14. Pay expenditure

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14A	In accordance with SOs the Board shall establish a Remuneration Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility.	14.1.1	Board	Director of Corporate Governance to ensure Committee in place
14B	The Remuneration Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.	14.1.2	Remuneration Committee Chair Board Chair supported by Director of Corporate Governance	Director of Corporate Governance to ensure reports from the Committee go to the Board No further delegation No further delegation
14C	The Board will, after due consideration and amendment, if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.	14.1.3	Board	People and Culture Committee

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14D	The workforce plans incorporated within the approved Integrated Medium-Term Plan will form the funded establishment, i.e., the budget for all approved posts.	14.2.1	Board to approve	Executive Director of People and Organisational Development All Executive Directors to contribute
14E	The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.	14.2.2	Chief Executive	Executive Director of People and Organisational Development and Executive Director of Finance
14F	No Board member or health board official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.	14.3.2	Chief Executive	Executive Director of People and Organisational Development and Executive Director of Finance
14F (i)	Agree acting up salaries for staff a) Staff up to Band 9, within budget. b) Staff Band 9 and above excluding Executive Directors c) Interim Executive Directors	Local	Chief Executive	a) Service Director (Tier 4) supported by Local People Services Team b) Chief Executive c) Remuneration Committee

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14G	Procedures to be presented by the Chief Executive for Board approval for the determination of commencing pay rates, condition of service, etc. for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies.	14.4.1	Chief Executive	Executive Director of People and Organisational Development
14H	The Executive Director of People and Organisational Development has responsibility for securing an efficient, well controlled payroll service.	14.5.1	Executive Director of People and Organisational Development	No further delegation
14I	The Executive Director of People and Organisational Development is responsible for: a) The control framework and detailed procedures which are in place to: - ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments, - reduce the risk of fraud and error within the payroll function. b) Specifying timetables for submission of properly authorised time records and other notifications;	14.5.2	Executive Director of People and Organisational Development	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements; d) Agreeing the timing and method of payment with the payroll service; e) Authorising the release of payroll data where in accordance with the applicable Data Protection Legislation; f) Verification and documentation of data; g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances; h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay; i) Security and confidentiality of payroll information; j) Checks to be applied to completed payroll before and after payment; and k) A system to ensure the recovery from those leaving the employment of the Health Board of sums of money and property due by them to the Health Board.			
14J	The Chief Executive is responsible for: a) Ensuring that any shared or hosted service arrangement is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and audit review procedures; b) Ensuring a sound system of internal control and audit review of any internally provided payroll service;	14.5.3	Chief Executive	a) Director of Corporate Governance b) Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
	c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.			c) Finance Director: Commissioning and Financial Planning
14K	Appropriately nominated managers have delegated responsibility for: a) Submitting time records, and other notifications in accordance with agreed timetables; b) Completing time records and other notifications in accordance with the Service Level Agreements; and c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Director of People and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Executive Director of Finance.	14.5.4	Line Managers	No further delegation

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
14L	Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and dealing with variations to, or termination of, contracts of employment	14.6.1	Executive Director of People and Organisational Development	No further delegation

Approve departure under compromise agreement (VERs) ○ Up to £50k (i & ii) ○ Above £50k (i, ii & iii)	i. All applications to be approved by Executive Director of People and Organisation Development, Chief Executive and Executive Director of Finance. ii. All applications also need to be approved by the Remuneration Committee iii. Any VER payments over £50k also need to be approved by Welsh Government.
Approve redundancy	Chief Executive and Executive Director of Finance and Remuneration Committee (subject to any Welsh Government approval mechanisms)
Approve departure under compromise agreement (other than VERs)	Executive Director of People and Organisation Development (subject to any Welsh Government approval mechanisms), Chief Executive and Executive Director of Finance

****Note: Any agreements that are deemed contentious to be referred to Remuneration Committee***

15. Capital Plan, Capital Investment, Fixed Asset Registers and Security of Assets

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15A	The Chief Executive is responsible for: (i) ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans; (ii) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; (iii) ensuring that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received; (iv) ensuring that the three-year Capital Plan and detailed annual Capital Programme is approved by the Board, as part of the IMTP, prior to the commencement of the financial year; (v) ensuring the availability of resources to finance all revenue consequences of the investment, including capital charges; and (vi) ensuring that any 3rd party use of NHS estate is properly controlled, reimbursed and reported.	15.4.1	Chief Executive	(i) Executive Director of Transformation and Strategic Planning (ii) Director of Environment and Estates (iii) Executive Director of Finance (iv) Executive Director of Transformation and Strategic Planning (v) Executive Director of Finance (vi) Director of Environment and Estates

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15B	For every capital expenditure proposal, the Chief Executive shall ensure: a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model; b) That the Executive Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Health Board personnel and external agencies in the process.	15.4.2	Chief Executive	Executive Director of Finance
15C	For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.	15.4.3	Chief Executive	Director of Environment and Estates and Executive Director of Finance
15D	The Chief Executive shall issue to the manager responsible for any scheme: a) Specific authority to commit expenditure; b) Authority to proceed to tender; c) Approval to accept a successful tender.	15.4.5	Chief Executive	Executive Director of Finance

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15D(i)	Professional advice on recoverable VAT is to be sought on all major Capital Expenditure Programmes. Advice to be sought for the conclusion of each project decision gateway to validate assumptions included within the Business Cases and Plans.	Local	Executive Director of Finance	Head of Capital Finance
15D(ii)	Any movement in contract retention values included in the original contract conditions and award criteria are to be approved by the Executive Committee (unless otherwise delegated)	Local	Executive Committee (unless otherwise delegated)	As delegated by Executive Committee
15E	The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the health board's SOs.	15.4.6	Chief Executive <i>[with advice from Executive Director of Finance]</i>	See below Table 15E (1) Detailed procedures are contained in the Health Board's Capital Manual

Table 15E (1) - Capital Schemes funded by Discretionary Allocation

Discretionary Capital Programme Approvals		Gross Expenditure on Whole Project	
Approval / Sign Off by:	Initial Annual Discretionary Programme	New Approvals Schemes under £500k	Scheme over £500K to £1m
Strategic Planning and Service Change Group (SPSC)			Agree project mandate and priority
Tier 4	Sign Abbreviated Business Case up to £50K	Sign Abbreviated Business Case up to £50K	-
Tier 3 or 4	Sign Abbreviated Business Case over £50K	Sign Abbreviated Business Case over £50K	Sign Abbreviated Business Case and Business Justification Case
Executive Director / Senior Responsible Officer (Tier 3 or 4)	-	-	Sign Business Justification Case
Executive Director of Finance (Tier 3)	-	-	Review and agreement
Capital Investment Group (CIG)	Recommend	Recommend	Recommend
Strategic Planning and Service Change Group (SPSC)	Recommend for onward consideration for board governance	Approve	Approve Business Justification Case
Performance, Finance and Information Governance Committee (PFIG)	Recommend	-	-
Health Board	Approve	-	-

Capital Schemes funded by Welsh Government

Strategic Planning and Service Change Group (SPSC) considers overall priorities and project mandates in advance of submission to Welsh Government for consideration (Executive approval required). For all-Wales capital schemes, the nature of the business case will be determined in discussion with Welsh Government.

Scheme under £1m	Scheme over £1m
Executive Committee considers overall priorities and project mandates (unless otherwise delegated)	
↓	↓
Scoping document submitted to Welsh Government (WG) followed by a scoping meeting with WG to jointly sign off	Scoping document submitted to WG followed by a scoping meeting with WG to jointly sign off
↓	↓
Business Justification Template signed off by lead Senior Responsible Officer and Executive Director	Strategic Outline Case signed off by Strategic Planning and Service Change Group (SPSC), Performance, Finance and Information Governance (PFIG) Committee and the Board
↓	↓
Capital Investment Group Recommend	Outline Business Case signed off by Executive Committee, PFIG Committee and the Board
↓	↓
Strategic Planning and Service Change Group Approve	Full Business Case signed off by Executive Committee, PFIG Committee and the Board
↓	↓
Submission to WG for approval	Final approval required from WG at each stage of Business Case process

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15F	The Executive Director of Transformation & Strategic Planning and Executive Director of Finance shall issue detailed procedures governing the project, financial management including variations to contract, of capital investment projects and valuation for accounting purposes.	15.4.7	Executive Director of Transformation & Strategic Planning and Executive Director of Finance	See Table 15F (1) below
15G	The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.	15.4.7	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
15H	Approval for any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and Third-party Developments, without the consent of the Welsh Ministers.	15.5.1	Welsh Ministers	No further delegation

Table 15F (1)- Capital orders and payment authorisation

ALL CAPITAL SCHEMES TO BE APPROVED AS PER TABLE 15E (1)

Leases over £250,000 are to be approved by the Executive Committee and reported to Performance, Finance and Information Governance (PFIG) committee.

Delegated authority	Variations to Discretionary Schemes	Variations to Capital Schemes funded by WG (within Approved Sum) *	Financial monitoring and reporting responsibility	Enter lease arrangement (all types) total value**
Up to £75k	Head of Capital	Head of Capital	Head of Capital	Executive Director (Tier 3 or 4) and the Executive Director of Finance
Up to £250k	Director of Environment and Estates	Director of Environment and Estates	Director of Environment and Estates	Executive Director (Tier 3 or 4) and the Executive Director of Finance
Up to £500k	Executive Director of Finance	Executive Director of Finance	Executive Director of Finance	Executive Director of Finance (following approval by the Executive Committee)
Up to £1 million	Chief Executive	Chief Executive	Chief Executive	Chief Executive (following approval by the Executive Committee)
Above £1 million	Board and Welsh Government (following consideration by PFIG)	Board and Welsh Government	Board and Welsh Government	Chief Executive (following approval by the Executive Committee, PFIG, Board and Welsh Government)

****Any variations to Capital Schemes funded by Welsh Government that exceed the approved sum require further approval from WG***

*****All property leases are to be signed under Seal***

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15I	The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Transformation & Strategic Planning and Executive Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically. The Health Board shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance. Additions to the fixed asset register must be clearly identified to the delegated budget holder and be validated by reference to appropriate documentation.	15.6.1 – 15.6.3	Chief Executive	Executive Director of Finance
15J	The Executive Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.	15.6.5	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
15K	The overall control of fixed assets is the responsibility of the Chief Executive.	15.7.1	Chief Executive	Executive Director of Finance
15L	All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Director of Transformation & Strategic Planning and Executive Director of Finance.	15.7.3	Executive Director of Finance, with support from relevant Directors.	Officers of health board
15M	Approval of routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.	15.7.4	Board All officers of health board	No further delegation

16. Stores and receipt of goods

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
16A	i) overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. (ii) The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager (iii) the control of any fuel, oil and coal shall be the responsibility of a designated Estates Manager.	16.2.1	Chief Executive	Executive Director of Finance Chief Pharmacist Director of Environment and Estates
16B	The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.	16.2.2	Executive Director of Finance	Service Directors
16C	Stocktaking arrangements shall be agreed with the Executive Director of Finance and there shall be a physical check covering all items in store at least once a year.	16.2.4	Executive Director of Finance	Direct to Operational Services

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
16D	Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Director of Finance	16.2.5	Executive Director of Finance	No further delegation
16E	For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Executive Director of Finance or authorised officer who shall satisfy themselves that the goods have been received before accepting the recharge.	16.3.1	Chief Executive	Executive Director of Finance

17. Disposals and condemnations, losses and special payments

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17A	The Executive Director of Finance must prepare detailed procedures for the disposal of assets, including condemnations, and ensure that these are notified to managers.	17.1.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
17B	All unserviceable assets shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Executive Director of Finance. The assets should be recorded on a form indicating whether they are to be converted, destroyed or otherwise disposed of. The form should be countersigned by a second officer authorised for that purpose by the Executive Director of Finance	17.1.3	Executive Director of Finance	Following advice from appropriate heads of service (e.g. IM&T, Estates, etc.) items with original value obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively may be condemned or otherwise disposed of in accordance with the delegations set out in Table 17B (1)

Table 17B (1)

Asset value:	Approved by:
With current/estimated purchase price below < £499	Budget Manager
with current purchase new price above >£500, up to <£5000	Relevant Executive Director
With current purchase new price above >£5,000, up to <£250,000	Executive Director of Finance following approval by the Executive Committee
With current purchase new price above >£250,000	Performance, Finance and Information Governance (PFIG) Committee
Disposal of property or land (all values)	Board and Welsh Government

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17C	The Executive Director of Finance shall ensure procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.	17.2.2	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17D	The Executive Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write off' action is recorded on the system.	17.2.8	Executive Director of Finance	Finance Director: Commissioning and Financial Planning
17E	The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs.	17.2.9	17.2.9	See Table 17E (1) Below

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
17F	The Executive Director of Finance shall ensure that all losses and special payments are reported to the Audit Committee at every meeting	17.2.13	Executive Director of Finance	Finance Director: Commissioning and Financial Planning / Director of Corporate Governance

Table 17E (1)

Ratify fruitless payments (including abandoned Capital Schemes)	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £250,000	Chief Executive and Executive Director of Finance
Above £250,000	Chief Executive, Executive Director of Finance and Welsh Government (following Executive Committee approval)

Ratify payment for clinical negligence and personal injury claims where legal advice has been obtained and guidance applied (negotiated settlements) *	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £500,000	Deputy Director for Legal Services
Up to £1 million	Director of Corporate Governance
Above £1 million	Chief Executive (following Board approval unless otherwise delegated) and Welsh Government
Other clinical negligence and personal injury claims where legal advice has not been obtained	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Director of Corporate Governance
Above £50,000	Welsh Government
Authority to write off losses and authorise special payments for bad debts and claims abandoned - private patients, overseas visitors and others.	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance

Above £50,000	Welsh Government
Authority to write off damage to buildings, fittings, furniture and equipment, loss of equipment and property in stores and in use due to culpable causes (e.g., fraud, theft, arson) or other.	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authorise compensation payments made under legal obligation (excluding Clinical Negligence and Personal Injury)	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £500,000	Deputy Director for Legal Services
Up to £1 million	Director of Corporate Governance
Above £1 million	Chief Executive (following Board approval unless otherwise delegated) and Welsh Government

Authorise extra contractual payments to contractors.	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authorise ex-gratia payments to patients and staff for the loss of personal effects	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive or Executive Director of Finance
Above £50,000	Welsh Government
Authority to write off Losses of cash due to theft, fraud, overpayment of salaries, wages, fees and allowances	<i>Audit Committee to regularly receive Schedule of Losses and Special Payments</i>
Up to £50,000	Chief Executive and Executive Director of Finance
Above £50,000	Welsh Government

*** For all clinical negligence and personal injury cases (including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more.
All structured settlements require approval from the Welsh Government H&SSG Director of Finance**

18. Digital, Data and Technology

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18A	The health board shall publish and maintain a Freedom of Information (FOI) publication scheme, or adopt a model publication scheme approved by the Information Commissioner.	18.1.2	Board	Chief Digital and Information officer
18B	The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of digital systems and data.	18.2.1	Chief Digital and Information officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18C	The Executive Director of Finance shall ensure that new financial data and systems, and amendments to current financial systems, are developed in a controlled manner and thoroughly tested prior to implementation.	18.3.1	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18D	The responsible Director for Digital Data and Technology has responsibility for ensuring that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the i) security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage; ii) availability of the service including resilience for continuity. The contract should also ensure rights of access for audit purposes.	18.4.1	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18E	Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall periodically seek assurances that adequate controls are in operation.	18.4.2	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18F	The responsible Director for Digital Data and Technology has responsibility for ensuring that the risks to the health board arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including business continuity and disaster recovery plan.	18.5.1	Chief Digital Information Officer	No Delegation other than responsibilities for security of patient data is delegated to the Executive Medical Director in their role of Caldicott Guardian
18G	All purchases of hardware and software must be undertaken in line with agreed IT policies, Procedures and contractual arrangements.	Requirement in support of SFIs	All Officers	
18H	No purchase or installation may be made of IT software whether new or upgrades to existing systems other than via the IT department	Requirement in support of SFIs	All Officers	

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
18I	Purchases of routine desktop hardware should be procured via health board contracts. Purchasing of servers should always be via IT	Requirement in support of SFIs	All Officers	

19. Patients' property

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
19A	Ensuring patients or their guardians are informed before or at admission, that the health board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt	19.2.1	Chief Executive Officer	Service Directors
19B	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	19.3.1	Executive Director of Finance	Service Directors
19C	Issuing property valued above >£5,000 only on production of a probate letter of administration	Local	Executive Director of Finance	Finance Director: Commissioning and Financial Planning

20. Funds Held on Trust (Charitable Funds)

The Health Board's Charitable Funds are managed through the registered charity with the Charity Commission (known as Awyr Las) and through the Charitable Funds Committee and its formal Trustee status

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
20A	The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of funds are to be taken and by whom	20.2.2	Board	See Table 20A (1) below
20B	Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Local	Executive Director of Finance	Head of Fundraising See Table 20A (1) below
20C	Legacies - Authority to accept the discharge of a donor's estate	Local	Executive Director of Finance	Not delegated

Table 20A (1) Charitable Funds

Item	Delegated authority
i. Approval and setting up of designated fund Advisors for new funds. ii. Approval of changes to Fund Advisors	i. Head of Fundraising with advice from relevant Director ii. Head of Fundraising with advice from relevant Director
New Fundraising Appeal: i. Up to £5,000 ii. Above £5,000, up to £25,000 iii. Above £25,000	i. Head of Fundraising with advice from relevant Director ii. Executive Director of Finance iii. Charitable Funds Committee
Expenditure requests for Charitable funds: i. Up to £5,000 (non-contentious) * ii. Above £5,000 and any contentious expenditure* iii. Above £1 million	To be submitted to Charity Team for initial review i. Fund Advisor (subject to confirmation from the Assistant Financial Accountant - Charitable Funds that sufficient funds are available and expenditure complies with Charity guidelines) ii. Charitable Funds Committee iii. Health Board and Welsh Government
Oracle approvals: i. Up to £5,000 ii. Above £5,000, up to £50,000 iii. Above £50,000, up to £250,000	Expenditure over £5,000 is only approved following prior approval by the Charitable Funds Committee i. Assistant Financial Accountant - Charitable Funds ii. Senior Financial Accountant - Charitable Funds iii. Finance Director – Commissioning and Financial

iv. Above £250,000, up to £500,000 v. Above £500,000	Planning iv. Executive Director of Finance v. Chief Executive

****The term “contentious” refers to the appropriateness of the expenditure either due to its nature or its compatibility with fund objectives as detailed in ‘Your Charity Procedures’.***

Investment of Charitable Funds

Investments Authority	
Investment of funds i. Decision on nature and value of investment ii. Risk level of investment fund	 i. Charitable Funds Committee with guidance from Executive Director of Finance ii. Charitable Funds Committee with guidance from Executive Director of Finance and appointed investment managers

*****The term “investment” refers to stocks, shares, bonds, property, unit funds or other instruments derived to generate a rate of return and/or valuation gains, other than interest bearing bank accounts***

21. Retention of Records

Ref	SFI requirement	SFI Ref.	Accountability for delivery and compliance with the SFI sits with	Related responsibilities delegated to
21A	The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of information Act 2000 (c.36).	21.1.1	Chief Executive	Chief Digital and Information officer / Executive Medical Director
21B	Approval for the destruction of records	Local	Chief Executive	Chief Digital and Information officer / Executive Medical Director

f

Audit Committee

COMMITTEE ASSURANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Pam Wenger, Director of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

a

Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol **Executive Summary**

This report provides the Audit Committee with a thematic review of the Alert, Assurance and Advice reports submitted by Board Committees, with the purpose of identifying recurring themes, systemic risks and areas where further assurance may be required. The review is intended to support the Committee in reaching a consistent and evidence-based view on the level of assurance it is able to provide to the Board.

The review identifies evidence of effective committee scrutiny, challenge and escalation across the Health Board's governance framework. Board Committees are providing oversight of significant organisational risks, including planned care recovery, urgent and emergency care performance, financial sustainability, quality and safety risks, workforce capacity, digital programme delivery, organisational culture and climate adaptation arrangements.

The report also identifies positive areas of assurance, including progress in planned care recovery arrangements, leadership development, recruitment and agency expenditure, maternity and neonatal outcomes, patient experience, strategic planning, integration of planning, finance and workforce arrangements, and strengthened governance in a number of areas.

Overall, the thematic review indicates that the Committee assurance framework is operating and that key risks are being identified and escalated appropriately. However, the recurring nature of several themes suggests that some challenges remain systemic and organisation-wide. Further assurance is therefore required on the pace of delivery, the effectiveness of mitigating actions, and the extent to which planned improvements are translating into measurable and sustainable outcomes.

The Audit Committee is asked to consider whether the thematic review accurately reflects the key assurance messages arising from Board Committee AAA reports, identify any additional cross-cutting themes requiring escalation, determine the level of assurance it is able to provide to the Board, and agree the final assurance statement for inclusion in its report to the Board.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
N/A		

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

AAA	Alert, Assurance and Advice
BAF	Board Assurance Framework
PFIG	Performance, Finance and Information Governance Committee
QSE	Quality, Safety and Experience Committee
PCC	People and Culture Committee
PPHP	Planning, Population Health and Partnerships Committee
UEC	Urgent and Emergency Care
EHR	Electronic Health Record
MH EHR	Mental Health Electronic Health Record
AAA	Alert, Assurance and Advice
BAF	Board Assurance Framework

COMMITTEE ASSURANCE REPORT

1. Y SEFYLLFA SITUATION

- 1.1 To provide the Audit Committee with a thematic review of the Alert, Assurance and Advice (AAA) reports submitted by Board Committees and to identify any recurring themes, systemic risks or areas where further assurance may be required.

1 Y CEFNDIR BACKGROUND

- 1.1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 1.2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

2 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

2.1 Committee Themes

Performance, Finance and Information Governance Committee

Key Alerts

- Planned Care recovery remains off trajectory, particularly in respect of 104-week waits, with limited confidence in deliverability.
- Urgent and Emergency Care performance remains fragile due to patient flow, delayed discharges and inconsistent improvement across sites.
- Delivery of a balanced budget remains challenging with increasing deficit pressures and a gap in deliverable savings.

Key Assurance

- Revised planned care recovery arrangements are being implemented.
- Early signs of improvement in waiting times are emerging.
- A Value and Sustainability Framework has been established.
- Improved business case governance arrangements are being developed.

Quality, Safety and Experience Committee

Key Alerts

- Continued risks associated with ambulance handover performance and delayed discharges.
- Risks associated with implementation of the Supreme Court Deprivation of Liberty judgment.
- Regulatory concerns following designation of the Emergency Department at Ysbyty Gwynedd as a Service Requiring Significant Improvement.
- Challenges associated with implementation of the Listening to People arrangements.

Key Assurance

- Positive patient experience.
- Strong cancer performance.
- Positive maternity and neonatal outcomes.
- Effective advocacy arrangements and Welsh language provision.

People and Culture Committee

Key Alerts

- Sickness absence remains above target.
- Workforce risks associated with Resident Doctor contract implementation.
- Capacity constraints impacting delivery of the Foundations for the Future Programme.

Key Assurance

- Progress in leadership development.
- PADR compliance remains above 80%.
- Improvements in recruitment and reduced agency expenditure.
- Strengthened workforce governance arrangements.

Planning, Population Health and Partnerships Committee

Key Alerts

- Delays to EHR and MHEHR programmes.
- Concerns regarding organisational culture, decision-making and risk aversion.
- Lack of an overarching framework and dedicated resource for climate adaptation and decarbonisation.

Key Assurance

- Progress in development of the Clinical Services Plan and Ten-Year Strategy.
- Improved integration of planning, finance and workforce arrangements.
- Continued focus on prevention and population health planning.

3 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS BOARD ASSURANCE FRAMEWORK / MATTERS FOR ESCALATION

Introduction to the Assurance Dashboard

The purpose of the Assurance Dashboard is to support the Audit Committee in reaching a consistent, transparent and evidence-based view on the level of assurance it is able to provide to the Board.

The dashboard draws together assurance information from Board Committee AAA reports and considers this through the Three Lines Model, assessing the extent to which:

- management controls are operating effectively (First Line);
- Board Committees are providing appropriate scrutiny, challenge and oversight (Second Line); and
- independent assurance supports confidence in governance, risk management and internal control arrangements (Third Line).

The dashboard is not intended to replace detailed committee discussions or professional judgement. Rather, it provides a structured framework to help the Committee evaluate assurance consistently across reporting periods, identify emerging trends and determine the overall level of assurance it wishes to provide to the Board.

In reviewing the dashboard, members are asked to consider not only whether risks are being identified and escalated appropriately, but also whether there is sufficient evidence that actions are being implemented effectively and are delivering sustainable improvements in organisational performance, governance and risk management.

The output of this assessment will support the Committee's determination of the level of assurance to be provided to the Board.

Committee	Principal Assurance Messages	Committee Assurance Assessment
Performance, Finance and Information Governance	Effective scrutiny of performance, financial sustainability and recovery planning. Significant concerns remain regarding planned care delivery, urgent and emergency care performance and achievement of a balanced budget.	□
Quality, Safety and Experience	Effective oversight of quality and safety risks. Continued concerns regarding ambulance handovers, regulatory compliance and implementation of improvement actions.	□
People and Culture	Positive progress in leadership development and workforce governance. Ongoing concerns regarding workforce capacity and sickness absence.	□
Planning, Population Health and Partnerships	Progress in strategic planning and transformation programmes. Risks remain regarding digital programme delivery, organisational agility and climate adaptation arrangements.	□
Charitable Funds Committee	Strong stewardship and financial governance. Opportunities exist to strengthen utilisation of charitable resources and demonstrate impact.	□

3.1 Proposed Assurance Statement for Consideration by Audit Committee

Following consideration of the thematic review of Committee AAA reports, the Audit Committee is invited to consider whether it is able to provide the following assurance to the Board:

Proposed Audit Committee Assurance Opinion

The Audit Committee has reviewed the AAA reports submitted by Board Committees and notes evidence of effective committee scrutiny, challenge and escalation of significant organisational risks and issues. The Committee considers that the Board can place reasonable reliance on the operation of the Committee assurance framework and the transparency of matters being reported through Board Committees.

The Committee notes that the reports collectively identify a number of recurring themes relating to:

- Delivery of improvement and transformation programmes;
- Financial sustainability and delivery of savings;
- Workforce capacity and organisational resilience;
- Governance effectiveness and organisational decision-making; and
- Demonstration of sustainable outcomes and benefits realisation.

The Committee is satisfied that these risks are being recognised, scrutinised and escalated appropriately through the Health Board's governance framework. However, the recurring nature of these themes indicates that a number of challenges remain systemic and organisation-wide rather than isolated to individual service, programme or committee areas.

The Committee therefore concludes that, whilst there is evidence of strengthening governance arrangements and active management of key risks, further assurance is required regarding the pace of delivery, effectiveness of mitigating actions, and the extent to which planned improvements are translating into measurable and sustainable outcomes for the organisation.

The Audit Committee is invited to:

1. Consider whether the thematic review accurately reflects the key assurance messages arising from Board Committee AAA reports.
2. Identify any additional cross-cutting themes requiring escalation to the Board.
3. Determine the level of assurance it is able to provide to the Board.
4. Agree the final assurance statement to be included in the Committee's report to the Board.

4 ARGYMHELLION RECOMMENDATIONS

4.1 Members are asked to:

- **NOTE** the thematic review of Board Committee AAA reports.
- **DETERMINE** the level of assurance the Committee is able to provide to the Board, taking account of the assurance framework, committee reporting and other sources of assurance.
- **AGREE** the Assurance Statement to be reported to the Board

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
<u>Answdd</u>	Galluogwyr Answdd	Meysydd Answdd

<i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality Leadership	Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report

<i>Have you undertaken a Data Protection Impact Assessment Screening?</i>		
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Do/Yes: ☐	Naddo/No: ☒
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required for this report
Cyfreithiol Legal	Yes (Include further detail below)	
	There are legal implications within the High Value Claims items reported	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	
Resource Impact <i>(People / Financial)</i>		

Audit Committee

Adroddiad Cydymffurfiaeth: Chwarter 1 2026-27

Conformance Report: Quarter 1 2026-27

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Denise Roberts, Head of Capital, Business Improvement and Compliance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Russell Caldicott, Executive Director of Finance

Pwrpas yr Adroddiad Report Purpose	For Noting & For Approval

Crynodeb Gweithredol

Executive Summary

This Conformance Report provides an update to the Committee on areas that relate to regulatory compliance or assurance and good practice expectations.

The areas covered in this report are:

- **Purchase orders that are non-compliant with SFI's (April – June 2026)**

This data set relates to orders being raised after the invoice has been received.

Non-compliance for the period is 250 in April, 174 in May and 163 in June 2026. The total 587 breaches during Quarter 1 (Q1) shows an improvement in performance compared to 693 in Q1 2025-26. A significant proportion of the orders are for known expenditure such as electricity, contractual clinical services and prescribing; however, the variable nature of the volume means that retrospective orders are produced.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure.

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).

During Quarter 1, the number of file notes approved was 22 with a total contract value of £1.6m.

- **Single Waivers (April – June 2026)**

The number of waivers issued year to date has decreased compared to this period last year.

Single Tenders – 3 approved in Q1, compared to 5 last year.

Single Quote – 4 approved in Q1, compared to 3 last year.

- **Receivables and conformance with payroll procedures**

The Health Board has procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 30th June 2026, there were 3,065 outstanding invoices, totalling £14m, of which 578 invoices, totalling £8.6m were less than 30 days old.

The Health Board places great importance on the requirement for accuracy of payments made to staff and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected over a period.

Staff Overpayment

For the period April to June 2026 there were 99 staff overpayments, with a gross value of £0.289m, comparable to 124 and £0.272m in the previous Financial Year. Failure to complete forms on time remains the main cause of overpayments (86 cases). Staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

As at 30th June 2026 the balance outstanding was £1.069m (30th June 2025 £1.061m).

Enhanced Establishment Control

An Enhanced Establishment Control Panel has been introduced to scrutinise Establishment Control Requests. The Executive Panel meet on a weekly basis to objectively review requests on an individual basis against agreed indicators.

A breach can occur if an individual is working to contract terms that have not been approved through the Establishment Control Process. During Quarter 1, one senior interim breach was reported.

- **Payables and conformance with Public Sector Payment Policy (PSPP)**

The Health Board aims to ensure that all balances are paid within 30 days of receipt of a valid payable invoice. Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date achievement for non-NHS invoices by number is 92.6%.

- **Losses and special payments**

Losses and special payments should be exceptional in nature. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

Clinical negligence claims are managed by Legal and Risk Services and there were 372 active claims at the end of June 2026. Of these, 203 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £274m (before reimbursement from the Welsh Risk Pool).

- **Welsh Risk Pool Penalties – Learning from Events Report**

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP) – reimbursement of a claim is conditional on this form being accepted by WRP and penalties are applied for delayed forms.

As at 30th June 2026 the number of claims outstanding is 14. This is an increase of 3 in the quarter.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau

Acronyms / Glossary of Terms

Appendix 1: Conformance Report – Quarter 1 (April to June 2026).

Section 1 - Conformance with Procurement Procedures

a) SFI requirements

The Health Board's Standing Orders (SOs), incorporating Standing Financial Instructions (SFIs), set the minimum thresholds for quotes and competitive tendering. These thresholds reflect relevant regulatory requirements, and are summarised in the following table:

Contract Value (ex VAT)	Minimum Competition
<£5,000	At discretion of appropriate Director
£5,000-£25,000	3 written quotations
£25,000-OJEU threshold	4 tenders
Above OJEU threshold (currently £118,133)	5 tenders
Contracts between £500k and £1 million	WG Ministerial Approval for noting *
Contracts above £1 million	WG Ministerial Approval required *

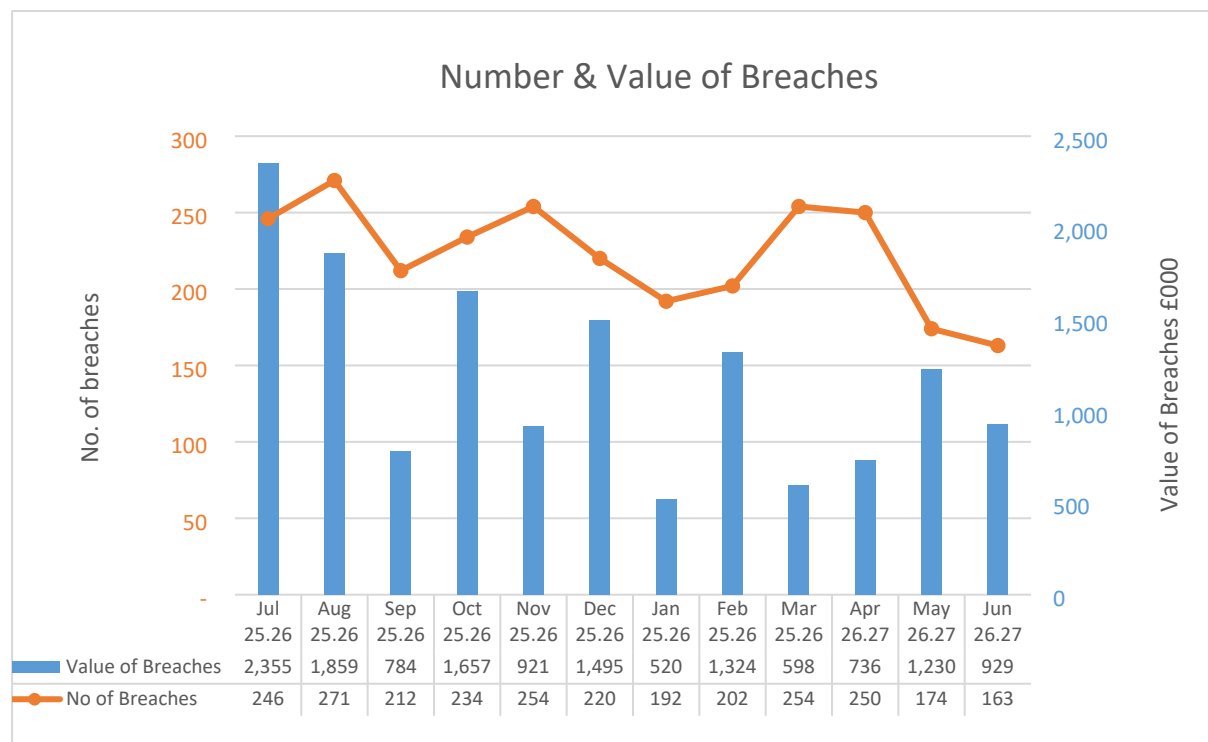
*Exemptions apply (see SFIs)

Compliance with the SFIs promotes effective control, value for money and ensures that the Health Board operates in compliance with relevant legislation.

b) Purchase Orders

The use of a formal purchase order system is a key control to ensure expenditure is only committed following proper approval and all committed expenditure is recorded. The trend in the graph below shows that there has been a 19% increase in the value of Purchase Order breaches in quarter 1 (Q1), with 587 breaches reported to the value of £2.9m. During the same period last Financial Year, the number of breaches were 693 with a value of £2.6m.

The value and number of breaches between July 2025 and June 2026 are detailed below:



The quarterly value of breaches by category are detailed below:

	2025-26				2026-27
Expenditure Type	Q1	Q2	Q3	Q4	Q1
Pay (Agency, Fees etc)	233,105	329,659	264,175	250,118	77,278
Managed Practices	39,166	179,627	111,163	68,044	44,777
Non-Pay	2,365,783	4,488,975	3,697,706	2,124,250	2,772,555
Total	2,638,054	4,998,261	4,073,044	2,442,412	2,894,610

There has been a significant reduction in the value of agency purchase orders following additional oversight and scrutiny for use of temporary workforce through the relevant Clinical Executive leadership and ceased use of non-clinical agency.

Of the 'No PO (Purchase Order) No Pay' breaches, the 5 individual orders with the highest value for Q1 are as follows:

Division	Month of Breach	Item Description	PO Amount £000's
Health Community East	Jun-26	BAYWATER (HOSNONVAT) - PROVISION OF HOME OXYGEN SERVICE ACTIVITY AND DAILY RENTAL CHARGES FOR VAT EXEMPT PATIENTS IN THE EAST AREA.	301
Health Community West	May-26	MODULAR UNIT INSOURCING SERVICES FROM 02.03.2026 - 31.05.2026	267
Utilities and Rates	May-26	YSBYTY GLAN CLWYD - ELECTRICITY CHARGES FOR PERIOD 1ST APRIL 2026 TO 31ST MAY 2026	248
Utilities and Rates	May-26	YSBYTY MAELOR WRECSAM - ELECTRICITY CHARGES FOR PERIOD 1ST APRIL 2026 TO 31ST MAY 2026	192
Health Community Centre	Jun-26	FIRST DRESSINGS SCHEME WITH NWOS CENTRAL AREA APRIL-JUNE 2026	144

The Divisions with the highest number of PO breaches have been listed below (£'000s):

Division	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD
East	68	72	77	75	88	70	58	87	102	82	71	48	201
Centre	92	112	122	71	114	53	35	65	60	57	39	47	143
West	60	80	37	43	54	38	58	48	51	50	49	44	143
Regional Services	20	49	20	20	25	20	24	14	20	39	22	15	76
Chief Digital Information Officer	38	24	20	1	37	19	6	19	36	30	19	20	69

Divisions have been reminded of the SFI requirements and to take action to ensure future breaches do not re-occur. An approved purchase order (PO) exemption list has now been issued and forms part of the updated No Purchase Order No Pay Policy on behalf of NHS Wales.

The Health Board's Oracle users are regularly reminded of the 'No PO No Pay' policy and that all staff must have approval before committing to expenditure. Reminder bulletins on procurement rules are issued in procurement communications.

NHS Wales Shared Services Partnership and the Health Board are continuously reviewing processes and resolving 'invoices on hold' issues, through the Accounts Payable function.

NHS Wales Shared Services Partnership (NWSSP) have worked with the Health Board to implement a new process involving 'File Notes' to capture and record instances of procurement spend outside of the SFIs/Scheme of Reservation and Delegation (SoRD).

During Quarter 1, the number of file notes approved was 22 with a total contract value of £1.6m. The table below provides detail for each file note:

FILE NOTE REFERENCE NO:	NAME OF SUPPLIER	DESCRIPTION OF GOODS OR SERVICES REQUIRED	REASON FOR BREACH	DEPARTMENT	CONTRACT PERIOD	TOTAL CONTRACT VALUE
2627-001-AC-BCU	ROYAL MAIL GROUP PLC	PAYMENT OF COLLECTION INVOICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	FACILITIES	ONE OFF	£250,000.00
2627-002-AC-BCU	PERINATAL INSTITUTE	GAP LICENSE RENEWAL	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	WOMENS SERVICES AND MATERNITY	12 MONTHS	£6,047.86
2627-007-AC-BCU	PATHWAY SOFTWARE LTD	THERAPY MANAGER	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	INTEGRATED HEALTH COMMUNITY WEST	12 MONTHS	£176,176.80
2627-009-AC-BCU	THE RENAL ASSOCIATION	UK KIDNEY ASSOCIATION DATA PROCESSING 2026 SYSTEM LICENSES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	DIGITAL AND INFORMATION	12 MONTHS	£4,152.84
2627-012-AC-BCU	OFFSITE ARCHIVE STORAGE AND INTEGRATED SERVICES (UK) LTD	STORAGE BOXES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	DIGITAL AND INFORMATION	ONE OFF	£9,184.90
2627-014-AC-BCU	CLINICAL SKILLS LTD	CLINICAL SKILLS SOFTWARE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	NURSING & MIDWIFERY	12 MONTHS	£14,462.00
2627-019-AC-BCU	KIT LOG LTD	PAPERTRAIL SUBSCRIPTION	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MEDICAL	12 MONTHS	£5,934.00
2627-021-AC-BCU	AQUILANT LTD	REPAIR OF CPAP MACHINE	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MEDICAL	ONE OFF	£5,845.21
2627-023-AC-BCU	OFFSITE ARCHIVE STORAGE AND INTEGRATED SERVICES (UK) LTD	EMERGENCY DEPARTMENT CASULTY CARD STORAGE AND SERVICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	DIGITAL AND INFORMATION	12 MONTHS	£6,300.00
2627-041-AC-BCU	TETRA TECH LTD	CONSTRUCTION ENVIRONMENTAL MANAGEMENT PLAN APPLICATION	EXTENDED WITHOUT APPROPRIATE AUTHORISATION	ENVIRONMENT AND ESTATES	ONE OFF	£6,245.00
2627-043-AC-BCU	SUPPLY POINT SYSTEMS LTD	MEDIWELL MAINTENANCE AND SUPPORT COVER	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PHARMACY	12 MONTHS	£41,410.00
2627-045-AC-BCU	WORK IN CONFIDENCE	WORKING IN CONFIDENCE PLATFORM	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	PEOPLE AND ORGANISATIONAL DEVELOPMENT	12 MONTHS	£21,891.00
2627-049-AC-BCU	EXACT SCIENCES UK LTD	CALL OFF ORDER FOR ONCOTYPE DX TESTS	EXTENDED WITHOUT APPROPRIATE AUTHORISATION	MEDICAL	12 MONTHS	£232,000.00

FILE NOTE REFERENCE NO:	NAME OF SUPPLIER	DESCRIPTION OF GOODS OR SERVICES REQUIRED	REASON FOR BREACH	DEPARTMENT	CONTRACT PERIOD	TOTAL CONTRACT VALUE
2627-054-AC-BCU	ROYAL MAIL GROUP PLC	PAYMENT OF COLLECTION INVOICES	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	FACILITIES	ONE OFF	£250,000.00
2627-056-AC-BCU	MEDSTROM LTD	PAYMENT OF OUTSTANDING INVOICES	EXTENDED IN EXCESS OF SFI ALLOWABLE LIMITS	MEDICAL	ONE OFF	£8,424.39
2627-057-AC-BCU	OTC DIRECT LTD NORTH WEST OSTOMY SUPPLIES (NWOS)	FIRST DRESSINGS SCHEME WITH NWOS - PAN BCU - APRIL TO JUNE 2026 - POs 10289023 (E508), 10289024 (E509) & 10289025 (E510)	EXTENDED WITHOUT APPROPRIATE AUTHORISATION	PHARMACY	2 MONTHS	£545,000.00
2627-058-AC-BCU	MAINTEL LIMITED	TELEPHONY SUPPORT 2 MONTHS	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	DIGITAL AND INFORMATION	ONE OFF	£7,500.00
2627-060-AC-BCU	DIRECT HEALTHCARE GROUP LTD	HIRE OF BARIATRIC EQUIPMENT	EXTENDED IN EXCESS OF SFI ALLOWABLE LIMITS	MEDICAL	ONE OFF	£6,764.23
2627-061-AC-BCU	GENEDRIVE DIAGNOSTICS LIMITED	NEONATAL GENTAMICIN POCT CONSUMABLES	URGENT ORDER IN THE INTERIM WHILST STA AND CONTRACT ARE BEING SIGNED OFF	WOMENS SERVICES AND MATERNITY	ONE OFF	£5,951.00
2627-063-AC-BCU	MEDSTROM LTD	DOLPHIN RENTAL EXTENSION OF HIRE ON FPR FOR 4 MONTHS	EXTENDED IN EXCESS OF SFI ALLOWABLE LIMITS	MEDICAL	ONE OFF	£8,296.00
2627-067-AC-BCU	ARJO UK LTD	BLOCK RENTAL - ENTERPRISE 5000X BED FRAME	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	MEDICAL	ONE OFF	£7,200.00
2627-083-AC-BCU	MAINTEL LIMITED	TELEPHONY SUPPPORT	COMPETITION NOT SOUGHT IN ACCORDANCE WITH SFIS	DIGITAL AND INFORMATION	ONE OFF	£307.80

c) **Single Tender Waivers (for items of expenditure above £25,000)**

It is normal practice to request bids from multiple suppliers. Where this is not possible, a single tender waiver should be obtained and approved ahead of expenditure being committed. Allowable rationale for a single tender waiver is:

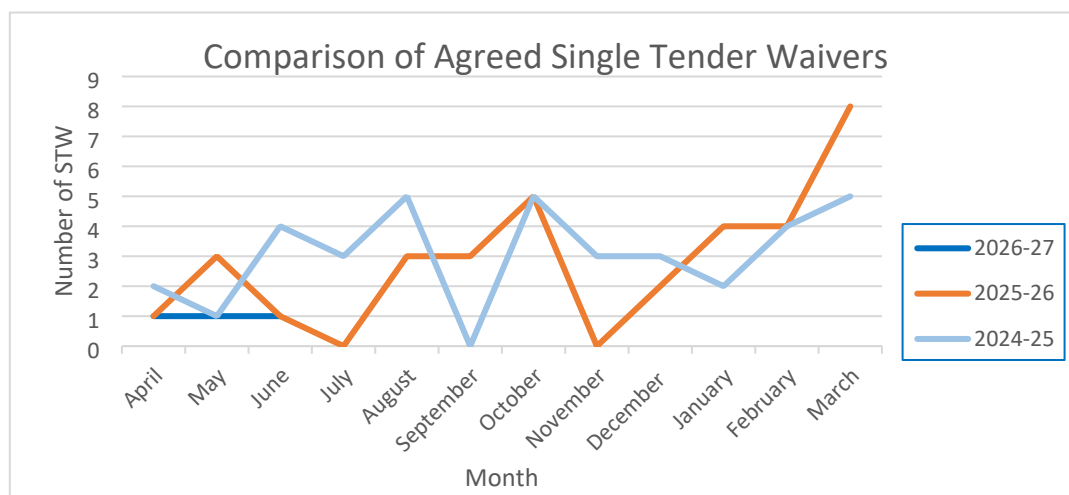
- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met, e.g., specific equipment required, or compliance with a warranty cover clause;
- A need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

The table below provides a summary of waiver activity for the year and the comparator data of last year.

Single Tender Waiver	2025-26 Q1	2025-26 FYE	2026-27 Q1
Waivers Issued	8	49	10
Waivers Approved	5	34	3
Value of Approved Waivers	£0.3m	£4.0m	£0.3m
Waivers approval above EU Threshold	1	8	1
Cancelled Waivers	2	6	0

The value of approved waivers has remained comparable to the same period last year.

The chart below provides a monthly profile of the approvals to waive tender requirements during 2026-27, compared with 2025-26 and 2024-25. Further information is detailed in **Appendix 2**.



Single Quote Waivers (for items of expenditure between £5,000 and £25,000)

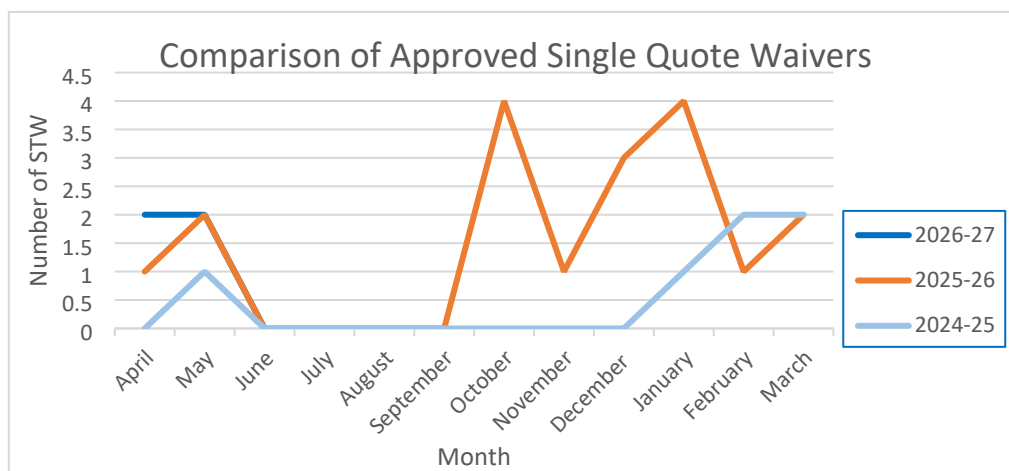
It is normal practice to obtain three quotes. Where this is not possible, then a single quote waiver should be obtained and approved ahead of expenditure being committed.

The table below provides a summary of waiver activity for the year and the comparator data of last year.

Single Quote Waiver	2025-26 Q1	2025-26 FYE	2026-27 Q1
Waivers Issued	13	43	18
Waivers Approved	3	18	4
Value of Approved Waivers	£0.1m	£0.2m	£0.1m
Cancelled Waivers	1	2	0

The number of approved waivers has increased compared to the same period last year.

The chart below provides a summary of the approvals to waive quote requirements for 2026-27, compared with 2025-26 and 2024-25. Further information is detailed in **Appendix 3**.



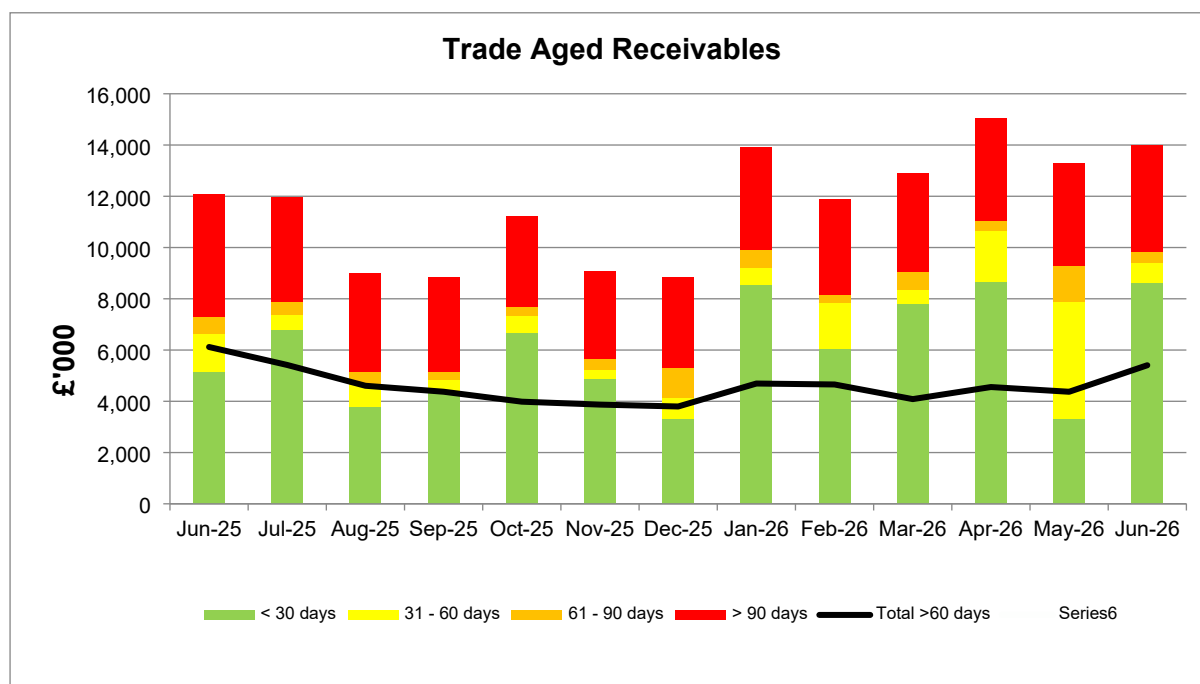
Section 2 – Receivables and Conformance with Payroll Procedures

a) Overview of Balances Owed

The Health Board has robust procedures in place to ensure that balances owed to the Health Board are invoiced promptly. Escalation procedures are in place to ensure that debtors are collected in a timely manner or highlighted for further action.

As at 30th June 2026, there were 3,065 outstanding invoices, totalling £14m, of which 578 invoices, totalling £8.6m were less than 30 days old.

The graph below shows the year-to-date trend in total debt and debt profile.



Provisions for bad and doubtful debts

The Health Board is required to maintain a bad debt provision against each outstanding invoice to cover the any future potential write offs. These provisions are calculated as a percentage of outstanding invoice values and are based on the type and value of each debt as well as historic collectability rates. Invoices are subject to further review on a quarterly basis to assess which bad debt provisions need to be increased to 100% due to specific risk of non-payment. All invoices that have been referred to the Health Board's debt recovery agents are automatically subject to a 100% bad debt provision.

Receivable balances over £10,000 and in excess of 6 months old as at 30 June 2026

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
NHS Cheshire and Merseyside ICB	353	11	8 invoices to the value of £290,036 have been cleared. Remaining balance £62,957 across 3 invoices.	Oct 23 to Aug 25
NHS Humber and North Yorkshire ICB	13	1	Awaiting response from the ICB regarding the invoice status and anticipated payment date.	Dec-25
The Walton Centre	117	4	All queries have been responded to by the Income Team. Recovery activity remains ongoing pending confirmation from the debtor that payment will be made.	Apr-22
Birmingham & Solihull Mental Health NHS Foundation Trust	60	1	Account has been escalated to Senior Management for review. BCU Service Lead is supporting ongoing recovery activity.	Aug-25
COUNTESS OF CHESTER FOUNDATION TRUST	13	1	Debtor advised payment has been processed on the 22nd July, with remittance expected by the 29th July 2026. Account subject to monitoring until payment has been received and reconciled.	Dec-25
Non NHS Company	37	1	Repayment arrangement agreed with CCI in June 2026.	Jan-25
Non NHS Company	21	1	Accounts Receivable Team continues recovery activity. No response has been received from the company. Invoice will be referred to CCI.	Sep-25
Overseas Patient	14	1	No response has been received from the debtor. Recovery letters have been returned undelivered. Account to be referred to CCI for further recovery action.	Jul-24
Overseas Patient	20	1	CCI returned the case, advising that all reasonable recovery activity had been exhausted. Write-off recommended.	Aug-22
Overseas Patient	28	1	CCI advised the debtor remains unable to settle the outstanding balance due to ill health and insufficient financial means. Write-off recommended.	Sep-22
Private Patient	10	1	Invoice raised for inpatient treatment has been referred to the patient's insurance company. Accounts Receivable is working with the insurer to obtain payment. Contractual restrictions preventing referral to CCI are being investigated.	Oct-20
Salary Overpayment	10	1	Repayment arrangement agreed.	Feb-24

Customer	£000's	Number of Invoices	Analysis and Further Action	Date Debt Raised
Salary Overpayment	16	1	Discussions ongoing with BCU Senior Workforce colleagues. Awaiting further information from the employee and advice from Workforce. Follow-up undertaken on 14 July 2026.	Feb-22
Salary Overpayment	14	1	Repayment arrangement agreed.	Dec-24
Salary Overpayment	10	1	Repayment arrangement agreed.	Mar-25
Salary Overpayment	28	1	Repayment arrangement agreed.	Dec-23
Salary Overpayment	10	1	Repayment arrangement agreed.	Feb-25
Salary Overpayment	10	1	Repayment arrangement agreed.	Aug-25
Salary Overpayment	14	1	On hold due to the debtor's long-term sickness absence (since 2025). A temporary low-value repayment arrangement has been proposed.	Aug-25
Salary Overpayment	13	1	Repayment arrangement agreed.	Sep-25
Q1 Total 2026-27	811	33		
Q4 Total	866	32		
Q3 Total	528	28		
Q2 Total 2025-26	1,464	54		
Movement in current quarter	(55)	1		

- *St David's Hospice - Agreed repayment plan over a 3-year period*

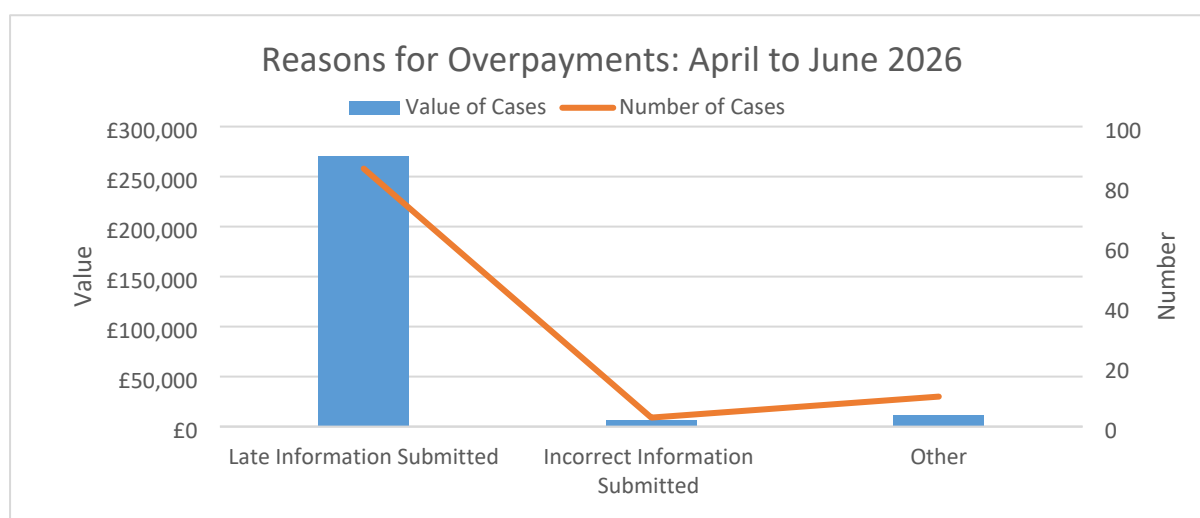
b) Staff Overpayments

The Health Board places great importance on the requirement for accuracy of payments made to staff and is particularly concerned to ensure that staff are not under or overpaid. While underpayments should be detected reasonably promptly through staff action, there is a risk that overpayments can remain undetected for some time.

	2025-26 Q1	2025-26 FYE	2026-27 Q1
Number of Salary Overpayments	124	443	99
Value of Salary Overpayments	£0.272m	£1.022m	£0.289m

For the period April to June 2026 there were 99 staff overpayments, with a gross value of £0.289m, comparable to 124 and £0.272m in the previous Financial Year.

Failure to complete forms on time remains the main cause of overpayments. The reasons for the overpayments are detailed below.



The Establishment Control (EC) team support an establishment control leaver management process.

The specific actions undertaken by the team are:

- Where an Establishment Control request details that a member of staff is leaving, the EC team send a leavers reminder e-mail. This reminds the manager to ensure they action the leaver form and consider items such as an exit questionnaire;
- There is a monthly review of EC requests which details a staff member is leaving. The team compare the details of the staff member noted on the EC request with the ESR Leavers Report and follow up the action with the EC requestor regarding why the team member hasn't moved departments or been terminated;
- The EC Team produces a monthly ESR Leavers Report, which is compared to the ESR Change Event Log by Division. This highlights the number of leavers terminated in ESR after the leaving date and is shared with Division for their information and action.

In addition, staff overpayment breaches are included in service/area monthly management reports and discussed as part of the budget monitoring process in order to improve future compliance.

It should be noted that overpayments as a result of internal process failures can affect the individual's universal credits, requiring the Health Board to write off the difference to ensure individuals income are not negatively affected.

Staff Overpayment Repayments

A robust and fair approach in the agreement of repayment periods is adopted to recover amounts as soon as possible; however, this can take a number of months especially where the error is attributed to the Health Board and immediate recovery would cause financial hardship.

As at 30th June 2026 the balance outstanding was £1.069m (30th June 2025 £1.061m).

The debt, by collection stage, is detailed below:

	No. of Cases	% of Total Outstanding	Value of Total Outstanding
Agreed Instalment Plans	276	44%	£0.500m
Collection Agents	152	24%	£0.273m
In Dispute or Under Review	116	19%	£0.189m
Reminder Stage	58	9%	£0.084m
Invoice Stage	19	3%	£0.023m

The Health Board expects salary overpayments to be repaid either in a single amount or over the period that the overpayment occurred, with a maximum limit of six months. Where individual circumstances would not make this possible, consideration is given to longer repayment periods following completion of a household income and expenditure account. Repayment plans in excess of six months are reviewed with the debtor on a regular basis.

The extremely aged debts are there because either:

- Former organisations agreed the repayment plans, or
- The HB is bound by legal orders applied on judgement, or
- Senior officers agreed plans over the normal maximum repayment period of 36 months.

NHS Wales Shared Services Partnership has approved and issued an All-Wales overpayment procedure that should strengthen the Health Boards current governance and processes on recovering salary overpayments. The procedure is due to progress to the People and Culture Committee for endorsement.

Establishment Control Breaches

An Enhanced Establishment Control Panel has been introduced to scrutinise Establishment Control Requests. The Executive Panel meet on a weekly basis to objectively review requests on an individual basis against agreed indicators.

The Panel will support the re-shaping of the organisation towards sustainability through skill mix and enabling changes to current structures where appropriate.

A breach can occur if an individual is working to contract terms that have not been approved through the Establishment Control Process. During Quarter 1, one breach was reported in relation to a senior interim appointment (0 Breaches were noted during Q4).

Section 3 - Conformance with Losses and Special Payments Procedures

Losses and special payments should be exceptional in nature and, where they do arise, are subject to additional scrutiny and reporting to the Audit Committee. The Health Board must administer losses in accordance with procedures set out by Welsh Government. Individual losses in excess of £50,000 require approval from the Welsh Government (£1,000,000 in the case of negligence claims).

The losses and special payments table below provides an overview of the losses incurred to June 2026. Clinical negligence claims account for the largest element of loss. Amounts in excess of £25,000 can be claimed from the Welsh Risk Pool Service in accordance with the risk pooling arrangements in place for NHS Wales. However, as the Welsh Risk Pool is funded from the NHS Wales healthcare budget these costs are still met by NHS Wales.

In common with the rest of the NHS, the Health Board has experienced an increase in the volume of claim activity within recent years, and the table below provides information in relation to clinical negligence claims. Clinical negligence claims are managed by Legal and Risk Services and there were 372 active claims at the end of June 2026. Of these, 203 matters were assessed as either probable or certain of settlement with a cumulative estimated value of £274m (before reimbursement from the Welsh Risk Pool). The table below shows the age profile of these claims.

45% of the caseload (169 matters) relate to claims in the early stages and whilst a significant number of these will be successfully defended, there are ongoing financial challenges. However, they are an indicator of future quality and require ongoing monitoring to ensure that any lessons are identified and actioned.

Year claim registered	No of claims
2026/27	35
2025/26	94
2024/25	66
2023/24	54
2022/23	40
2021/22	23
2020/21	25
2019/20	21
2018/19	7
2017/18	0
2016/17	2
2015/16	0
2014/15	1
2013/14	0
2012/13	0
2011/12	1
2010/11	1
2009/10	1
2008/09	1
Total claims	372

Losses and Special Payments

	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Latest quarter analysis and further action
	£	£	£	£	
Medical Negligence					
Gross cost	7,964,638	4,415,231	13,435,995	12,585,775	Payments were made on 163 cases, of which 19 came under the Redress Scheme
WRPS Reclaim	-7,228,209	-3,516,837	-12,662,834	-11,662,152	
Net Cost	736,429	898,393	773,161	923,623	
Personal Injury					
Gross cost	64,059	250,999	228,509	154,254	Payments were made on 62 cases.
WRPS Reclaim	-36,000	-148,243	-97,112	-66,712	
Net cost	28,059	102,756	131,397	87,542	
Loss of cash	0	1,185	420	130	There were 2 claims for loss of cash in Q1 relating to patient monies, one claim related to a banking issue and one claim related to cash that went missing from a safe. Claims are referred to the police and counter fraud where necessary.
Debtors written off	18	170,575	34,753	0	A data cleanse of outstanding invoices is being undertaken and a number of aged debts are being written off where all debt collection efforts have been exhausted, or the debt has met the statutory regulation.
Loss or damage to equipment, property and stock	59,265	359,887	159,402	278,822	Relates to the loss of Pharmacy stock due to damage, breakages or expiry and obsolete stock written off. There are plans in place to improve this performance through introducing Pharmacy Automated Vending machines and aligning controls across the Health Board.
Ex-gratia payments	141,095	7,720	103,550	14,814	Relates to 13 payments for loss/damage of patient's property, 4 ombudsman payments for delayed and unsatisfactory treatment.
VERS Payments	0	0	0	0	All payments are approved by the Remuneration Committee.
Total	964,866	1,540,516	1,202,683	1,304,931	

* The Welsh Risk Pool Service administers the risk pooling arrangement for negligence claims and reimburses amounts over £25,000

Section 4 – Welsh Risk Pool Penalties – Learning from Events Report

Learning from Events Report (LFER) forms are a mandatory part of the national claims and redress process to evidence learning, within deadlines for submission set by the Welsh Risk Pool (WRP).

WRP can levy a penalty for late submissions, which is recharged to divisions where the LFER or supporting evidence is late. At present, the penalty is £2,500 per late submission (which can recur).

66 penalties were applied in the financial year 2024-25, 29 in the financial year 2025-26, and zero penalties during Q1 2026-27.

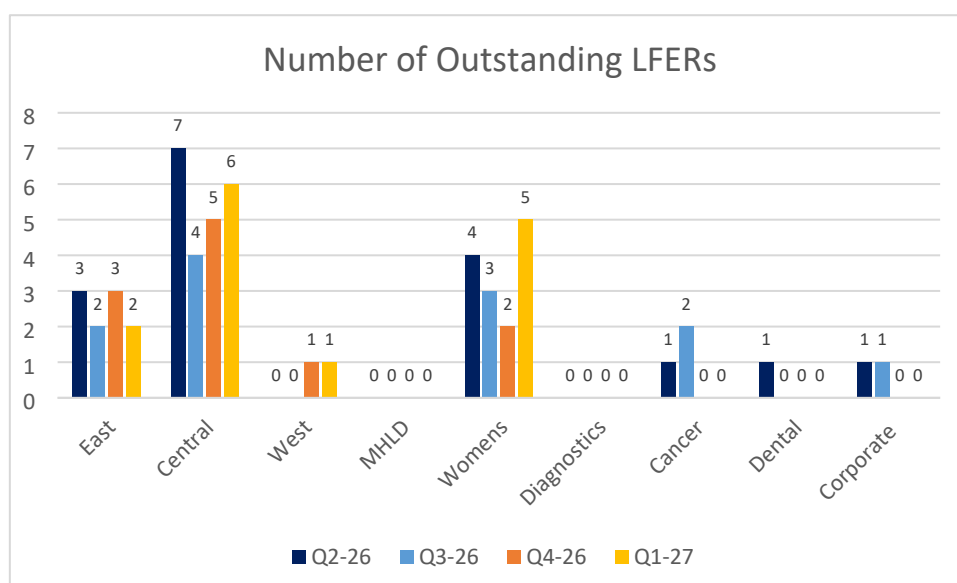
The Health Board has implemented a clear process, and data is provided to divisions on a weekly basis to support local performance management and recovery of overdue submissions in real time. A bi-weekly meeting is held to support and scrutinise the division's performance. All divisions have now embedded LFER monitoring into their governance structures.

At 30th June 2026 the total number of outstanding LFERs was 14 (31st March 2025, 11).

The overdue LFERs, by category and division, are detailed below:

IHC/Division	Claims	Claims Deferred	Redress	Redress Deferred	Total
East	1	1	0	0	2
Central	2	1	2	1	6
West	0	0	1	0	1
MHLD	0	0	0	0	0
Womens	0	4	1	0	5
Diagnostics	0	0	0	0	0
Cancer	0	0	0	0	0
Dental	0	0	0	0	0
Estates	0	0	0	0	0
Total	3	6	4	1	14

The chart below provides a summary of the outstanding LFER's per quarter:



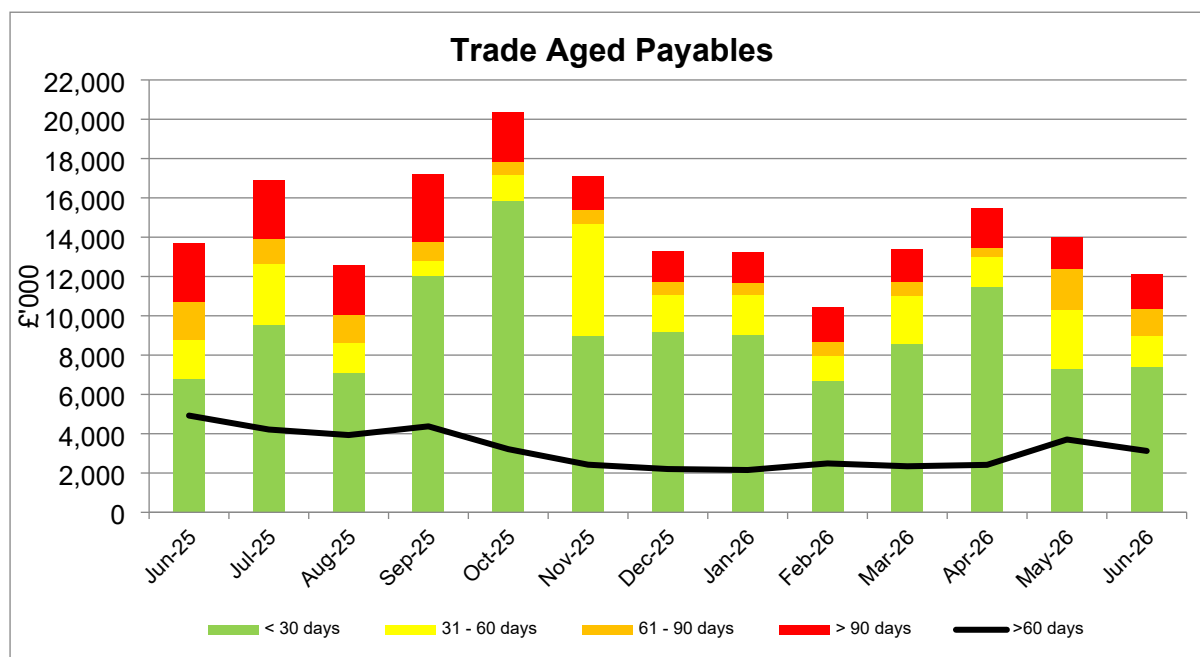
Section 5 - Conformance with Payable Procedures

PSPP Conformance

The Health Board aims to ensure that all balances are paid within a reasonable timeframe (or received for receivables), mainly within 30 days of receipt of a valid payable invoice (or issue of a receivables invoice). Best Practice of 95% (by number) is set for non-NHS invoices at 95%. The year-to-date performance for non-NHS invoices by number is 92.6%, which falls below the target due to a number of invoices for a specific supplier being paid late. Additional measures have been put in place to avoid reoccurrence in future months.

High Value (£10,000 plus) Exceptions

The chart below provides an analysis of the trade payables by month.



The high-value (£10,000 plus) exceptions, over 6 months old, are listed in the table below. High value invoices are reviewed on a monthly basis and action is taken to resolve the disputes/queries

Payable balances over 6 months old and over £10,000 as at 30th June 2026

Supplier	£000's	No of Invoices	Analysis and further action	Invoice Date
Other Public Sector Organisation	146	1	Query over contract being signed before payment can be made - awaiting update from service	Jun 2025
Limited Company	88	3	Interest Claimed by Supplier in line with the Late Payments of Commercial Debts (Interest) Act 1998, invoice disputed by DOF	Jun, Jul & Aug 2025
Limited Company	80	1	Duplicate invoice, supplier has been notified and a credit has been requested	Nov-25
Limited Company	51	2	Duplicate invoice, supplier has been contacted requesting a credit. Price incorrect credit has been requested	Mar 23 & Oct 25
Limited Company	38	2	Requisitioner states goods have not been received, supplier has been contacted to request a proof of delivery. Company is unable to provide PoD due to the length of time. Refer to management for advice. Overcharge on invoice, requisitioner has provided copy credit which has been forwarded to Accounts Payable for processing	Sep 22 & Dec 25
Limited Company	17	1	Call off PO has been raised but the full amount of the invoice has not been receipted, the requisitioner has been asked to confirm if there is an overcharge on the invoice	Nov-25
Limited Company	11	1	Query over whether part of the order has been delivered, the requisitioner has been contacted to provide confirmation	Oct 2025
Limited Company	10	1	The requisitioner has provided a copy of the quote, it appears the supplier has made a small overpayment, The company have been contacted to request a credit	Dec 2025

Appendix 2 - Approved Single Tender Waivers >£25K between 1st April – 30th June 2026

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
2025/2026-1645	14/05/2026	Operational Estates - West	Honeywell	This STW is being sought for the maintenance of the Fire Alarm systems within the community sites of the West region of BCU for 2 years. Honeywell are the manufacturers, designers, installers, commissioners and service providers of the Fire Alarm systems, which are closed protocol. The total annual cost for the contract is £29,908.91, which totals £59,817.82 for the 2 years. The difference of £20,182.18 equalling £10,091.09 per year for call outs and the purchase of spares as required. As this contract covers multiple sites then there will be several cost centres used as detailed below; S554 - NHS Direct YG - £1,351.00 S554 - Trust Management Centre YG - £3,487.54 S529 - Eryri - £4,033.74 S500 - Alltwen - £21,036.63	Genuinely one provider	£80,000.00	Accept	Procurement supports the approval of this waiver on the basis of a sole supplier justification due to technical exclusivity. The existing Fire Alarm systems across the identified BCU West community sites are manufactured, designed, installed, commissioned, and maintained by Honeywell, and operate on a closed protocol. This restricts access to system software, components, and maintenance functionality to the original manufacturer and its authorised providers, meaning there is no viable alternative supplier capable of delivering this service. The systems are already fully installed and operational across multiple sites, and any attempt to engage a third-party provider would not be technically feasible without significant system replacement, risk to system integrity, and potential disruption to critical fire safety coverage. Such changes would also incur substantial additional costs and could introduce compliance risks in relation to statutory fire safety obligations. The proposed contract value of £59,817.82 over two years is considered proportionate to the scope and criticality of the service being delivered across multiple cost centres and locations. Maintaining the current arrangement ensures continuity of service, system reliability, and ongoing compliance with fire safety regulations. Failure to approve this waiver would result in the systems being left unserviced and potentially inoperable	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
								in the event of faults, posing a significant risk to life safety and service delivery. This waiver is therefore supported in line with procurement regulations under technical exclusivity and absence of competition. It is recommended that the requirement is reviewed periodically to ensure the justification remains valid and to consider any future market or technological developments that may introduce competition.	
2026/2027-1654	16/04/2026	DSCSS - Pathology	Checkit	Temperature monitoring solution, including alerts and notifications, maintenance of system and calibration of temperature monitoring probes.	Maintenance	£50,200.32	Accept	Procurement Services accept this waiver request due to the Sole Supplier nature of the required maintenance. Following discussion with the relevant department, Checkit UK Ltd has been deemed the Original Equipment Manufacturer (OEM) capable of maintaining the equipment in full compliance with manufacturer specifications and guidelines. Due to the proprietary and specialist nature of the equipment, no alternative supplier has access to the OEM-approved components, software, or technical knowledge required to deliver the maintenance to the necessary standard. Approval of this contract will ensure the continued safe and effective operation of critical temperature monitoring equipment, which plays a key role in supporting regulatory compliance, and service resiliency. Maintaining this equipment in line with OEM requirements mitigates the risk of equipment failure and potential service disruption. Non-approval of the waiver would have a direct and detrimental impact on service delivery, resulting in non-compliance with maintenance requirements and increased operational risk. This could lead to equipment downtime, escalation of patient	No

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice	Breached FTS
						£000s			
								safety concerns, and potential regulatory implications. On this basis, procurement approval of the waiver represents the most appropriate, proportionate, and risk-managed approach to ensuring continuity of service. Joe Angell - Procurement Business Officer 10/04/2026	
2026/2027-1676	05/06/2026	Therapies	Health Care Matters	Maintenance of Community Equipment	Interim arrangement pending tender	£200,000.00	Accept	Procurement supports this waiver request as an interim measure pending the award of the tendered contract renewal (BCU-FTS-60443), which is currently with Welsh Government for ministerial approval to award. An extension has become necessary due to unexpected governance delays which have prevented a timely contract award ahead of the current contract expiry date of 30th June 2026 (BCU-DIR-59836). This 3-month extension period will allow all necessary approvals to be concluded, a standstill period to be offered and will facilitate an implementation phase with the new provider. Following full approval of this waiver, a transparency notice will need to be issued to the market outlining the Health Board's intention to direct award this 3-month extension contract to the incumbent provider. This will be subject to a standstill period of 8 working days before any contract award can be made. Procurement Ref: BCU-DIR-63043	Yes

Appendix 3 - Approved Single Quote Waivers >£25K between 1st April 30th June 2026

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
2025/2026-1652	16/04/2026	Estates and Facilities	Trane	"This STW is being sought for the maintenance program for the Trane chillers on the Ysbyty Gwynedd site. Many of these units are now at an age where they are becoming more problematic and costly to repair, which include the main site chillers that supply cooling to the main air handling systems for the operating theatres and if they were to breakdown then this would have serious consequences on the temperature control for the theatres. The controllers on these units are closed protocol, therefore a third party would be unable to access the controller program software.	Maintenance	£20,000.00	Accept	This Single Tender Waiver (STW) is requested to support the continuation of an existing maintenance arrangement for the Trane chillers located at the Ysbyty Gwynedd site. Due to the proprietary nature of the Trane chiller control systems, which operate on a closed protocol, only the original manufacturer or their authorised service provider is able to access, maintain, and support the control software. As such, there is no viable alternative supplier capable of delivering this service without significant technical and operational risk. Given that these chillers serve critical clinical environments, including operating theatres and other essential departments, maintaining continuity of service is paramount to ensure patient safety and operational resilience. Any disruption to the maintenance provision could result in system failure, leading to loss of temperature control in high-risk areas. This requirement represents a continuation of an existing arrangement and is funded through existing core contract budgets. The waiver is therefore justified on the grounds of technical exclusivity and the need to ensure uninterrupted service delivery for critical infrastructure. Future replacement or upgrade strategies should be considered as part of the long-term asset

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
								management plan to mitigate ongoing risks associated with aging equipment.
2026/2027-1653	16/04/2026	Corporate	PrescQIPP	The annual cost for the contract is £13,646 and have included a contingency of £6,354 to allow for spares etc during the contract period."	Genuinely one provider	£18,459.00	Accept	Procurement supports this waiver on the basis that the Health Board have confirmed there is no comparable subscription available within the market and without this subscription the Health Board would have a increase clinical risk because PrescQIPP provides structured guidance on high risk medicines, deprescribing, and safety alerts. Lack of access may delay implementation of best practice and increase variation in clinical decision making.
2026/2027-1655	14/05/2026	Corporate - WOD	Page Tiger	There is no other company that do the same thing as this organisation. It is a long-standing subscription that is renewed annually. PrescQIPP offers a comprehensive, evidence-based subscription service designed to improve medicines-related care by giving pharmacists, pharmacy technicians, and wider healthcare teams access to high-quality clinical resources, implementation tools, and regularly updated data intelligence dashboards at national, Health Board, practice, and where possible patient level. The service delivers time-saving clinical bulletins, toolkits,	Genuinely one provider	£6,390.00	Accept	Procurement support this waiver for this years renewal to ensure continuity of service and ensure live documents are not lost. Procurement advise ahead of the next renewal for the Health Board to engage in a pre market exercise or quotation exercise to understand the market position and check whether there are any competitors/alternatives within the market as the position may have changed from when first taking on these licenses.

Ref No.	Date of Financial Approval	Area	Name of Supplier	Description	Rationale	Value	Supported By Procurement	Procurement Advice
						£000s		
				patient-facing materials, audit templates, and decision aids, alongside flexible learning and development opportunities such as expert-led training, CPD-accredited e-learning, virtual professional networks, and guidance on using the platform's resources effectively. Subscribers also benefit from regular updates on new materials and opportunities to shape future content, supporting Betsi Cadwaladr University Health Board's ambition to become a high-quality organisation by accelerating improvements in medicines optimisation and patient care.				
2026/2027-1658	14/05/2026	Secondary Care - North Wales Cancer Services	System C	Software platform used by BCU to create and share online content such as handbooks, training material etc to support our staff in areas such as recruitment - onboarding, Leadership training as part of the framework. Health resources - staff wellbeing, Culture Leaders resources etc. We have reduced the number of licences to reduce costs for this year by over £ 1500 from the previous contract.	Genuinely one provider	£6,360.00	Accept	Procurement Support this waiver on the basis of a sole supplier for this requirement due to that System C are the only provider to be able to provide the server upgrade to their existing system within the Health Board. - Olivia Anderson - Procurement Business Officer

ASESIAD / Assessment	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    
	1. Building an effective organisation
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Not Applicable.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not Applicable.</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not Applicable
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Data to Knowledge	Meysydd Ansawdd Domains of Quality Effective
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:

	If more than one applies, please list below:	If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable.
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable.
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll? Counter Fraud Impact Assessment Have you considered the counter fraud impacts	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable.

	If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

Audit Committee

INTERNAL AUDIT PROGRESS REPORT

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dave Harries, Head of Internal Audit, CMIA Nicola Jones, Deputy Head of Internal Audit, CMIA
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

The progress report summarises fourteen reviews finalised since the last Committee meeting in April 2026, with the recorded assurance as follows:

- Reasonable assurance – three
- Limited assurance – seven
- Unsatisfactory assurance – one
- Advisory/Assurance not applicable - three

The report also provides the final status of the 2025/26 Audit Plan.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

DDaT CfMHaS UEC	Digital Data and Technology Directorate Centre for Mental Health and Society Urgent and Emergency Care

INTERNAL AUDIT PROGRESS REPORT

1. Y SEFYLLFA SITUATION

- 1.1 The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing Internal Audit Assignment reports.

2 Y CEFNDIR BACKGROUND

- 2.1 The report provides details of audit reports issued as final and the status of the 2025/26 internal audit plan.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

- 3.1 Seven limited assurance and one unsatisfactory assurance have been issued in the period:
- 3.2 Speaking Up Safely; Planned Care Major Change Programme – Governance and Delivery; Executive Committee: Governance; Non-DDaT controlled IT; Standards of Business Conduct; Pharmacy Regulatory Requirements; Challenged services – Improvement and Nuclear Medicine Consolidation Project.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

- 4.1 There are no specific risks other than those relating to individual reviews / findings.

5 ARGYMHELLION RECOMMENDATIONS

- 5.1 The Committee is asked to:
- **Note** the findings within the progress and associated audit reports.



ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	    
	1. building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Wise Spending Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	N/A other than those relating to individual audit reviews / recommendations.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Equality duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports). The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Socio-Economic duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports).
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Armed Forces Covenant Due Regard duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports).
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	There is no identifying information included in the progress report or reports.
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	Counter Fraud considerations are taken into account for all relevant audit reviews.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Internal Audit Progress Report

Audit Committee

9 April 2026 to 31 July 2026

Betsi Cadwaladr University Health Board

Contents

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Introduction

This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plans for 2025/26 and 2026/27.

Reports Issued

Since the last progress report, fourteen reviews have been issued as final.

Table 1: Summary of final reports issued

Review	Assurance rating	Key issues
Purchase Cards & Petty Cash (BCU-2526-42)	Reasonable	The review found that the Health Board is broadly compliant with its petty cash and purchasing card procedures, with generally robust controls and no significant weaknesses identified. Areas for improvement include introducing formal training and refresher awareness sessions for cardholders, strengthening security arrangements at some cash-holding locations, ensuring monthly independent checks are consistently evidenced, and obtaining signed agreements from all historical purchasing card holders.
Budget Setting (BCU-2526-09)	Reasonable	The review concluded that the Health Board has established arrangements for allocating resources in line with its financial plan, although achieving a balanced budget remains heavily dependent on delivering planned savings. Key areas for improvement include introducing a more consistent approach to triggering financial recovery plans for overspent areas and ensuring all budget holders complete and return accountability agreements, while the ongoing Foundations for the Future programme provides an opportunity to strengthen budgeting processes further, including the potential adoption of zero-based budgeting principles.
Sickness Management – Corporate Directorates (BCU-2526-41) (2026/27)	Reasonable	The review found that corporate directorates are generally complying with the NHS Wales Managing Attendance at Work Policy and that arrangements to manage attendance are operating effectively. Key improvements include increasing uptake of manager training on attendance management, enhancing the value of Occupational Health reports, and strengthening engagement between People & OD Business Partners and

		directorate leadership teams to support proactive absence management.
Centre For Mental Health and Society (BCU-2526-44)	Advisory	The review found that the long-standing arrangement between the Health Board and Bangor University's Centre for Mental Health and Society has not been formally reviewed since 2012, with increased costs, undocumented changes, and insufficient evidence to demonstrate value for money, benefits to the North Wales population, or compliance with key governance and financial requirements. Significant concerns were also identified regarding potential duplicate funding, weaknesses in contract and honorary appointment processes, incomplete declarations of interest, and the need for a comprehensive review of future research and academic partnership arrangements to improve accountability, compliance, and effectiveness.
Urgent and Emergency Care: Implementation of Audit Wales actions (BCU-2526-20)	Assurance applicable not	The follow-up review found that governance and oversight arrangements for Urgent and Emergency Care (UEC) have improved, with strengthened programme management, regular performance reporting, and progress against most of the recommendations from the Audit Wales review, although performance against several national targets remains significantly challenged. Of the fifteen recommendations, seven have been implemented, six are partially implemented, and two are not yet due for completion, with ongoing work to strengthen risk management, assurance arrangements, and delivery through the UEC Programme.
Capital Governance Arrangements (BCU-SSU-2526-43)	Advisory	The advisory review found that the Health Board's arrangements for overseeing and delivering major capital projects require significant strengthening, particularly in relation to governance, procedures, accountability, and the clear definition of roles and responsibilities. It also highlighted that many of the issues identified in previous reviews of major capital projects, including governance weaknesses and project delivery challenges, remain evident, indicating a need to urgently reset capital governance arrangements.

Speaking Up Safely (BCU-2526-25)	Limited	The review found that while the Speaking Up Safely process is accessible, weaknesses in oversight, case management, staff feedback, and assurance reporting mean the Health Board cannot demonstrate that concerns are consistently resolved effectively or in line with national requirements. Key improvements are needed to fully align local arrangements with the national framework, strengthen training compliance and monitoring, improve scrutiny and reporting, reduce delays in case resolution, and provide assurance that staff who raise concerns are protected and supported.
Planned Care Major Change Programme – Governance and Delivery (BCU-2526-19)	Limited	The review found that while formal governance, systems, and processes are in place to support the Planned Care Major Change Programme, delivery has been delayed and is not progressing consistently against agreed timescales. Key concerns include weak assurance and reporting arrangements to the Executive Committee and Board, significant slippage against project milestones, a leadership gap within two workstreams, and a risk that planned programme benefits and delivery targets will not be achieved within the expected timeframe.
Executive Committee: Governance (BCU-2526-05)	Limited	The review concluded that although the Executive Committee has improved transparency and visibility of Executive decision-making, it is not operating fully in accordance with its Terms of Reference, with significant weaknesses in governance, reporting, and assurance arrangements. Key improvements are required to address compliance issues, strengthen oversight and accountability, ensure all delegated responsibilities are discharged, and improve reporting from groups and programmes to support effective decision-making. The Executive Committee cannot be established as a Committee of the Health Board as it conflicts with Standing Order 3.4.6.
Non-DDaT controlled IT (BCU-2526-16)	Limited	The review found that while the Health Board has some controls in place to manage digital systems and medical devices, significant weaknesses exist in governance, oversight, asset management, and cyber security

		arrangements for IT systems managed outside of Digital Data and Technology (DDaT). Key concerns include inadequate policies and guidance, incomplete records of software and medical devices, inconsistent approval and procurement processes, poor visibility of software in use, and security risks arising from unsupported or uncertified systems and unchanged default passwords on medical devices.
Standards of Business Conduct (BCU-2526-04)	Limited	The review found that although controls and systems for managing declarations of interest, gifts, and hospitality have improved since the previous audit, significant weaknesses remain in compliance, oversight, and monitoring arrangements. Key concerns include low declaration rates among senior staff, limited reporting to Executive and Audit Committee, delays in recording gifts and hospitality, system limitations that restrict compliance monitoring, and a lack of assurance that declarations are being managed effectively across the Health Board.
Pharmacy Regulatory Requirements (BCU-2526-40)	Limited	This review was requested by the Health Board. We found that governance, leadership, and compliance arrangements for meeting General Pharmaceutical Council standards are not operating effectively, with clarity required of the Chief Pharmacist's role. At the IHCs issues relating to leadership accountability, staff awareness of governance processes, and corporate oversight were evident. Key issues include inconsistent understanding of responsibilities and escalation processes, low confidence in reporting concerns, variable operational practices and support for staff, underdeveloped monitoring of improvement actions, and a lack of routine assurance reporting to the Chief Pharmacist.
Challenged services – Improvement plans (BCU-2526-30)	Limited	The review found that although all challenged services have improvement plans in place, there are significant weaknesses in their consistency, delivery, governance, and assurance arrangements. Key concerns include variable quality and detail of plans, delays in implementing actions without updated timescales, gaps in clinical leadership and local governance

		arrangements, and insufficient assurance reporting to the Executive Committee.
Nuclear Medicine Consolidation Project (BCU-SSU-2526-45)	Unsatisfactory	The review found that although the project remains strategically important and has Board support, unresolved revenue affordability issues, delays in responding to Welsh Government scrutiny, and weaknesses in project governance have prevented funding approval and increased delivery risk. At the time of reporting, key actions required included confirming the project's financial viability (revenue and capital), strengthening reporting and accountability arrangements, appointing key project and cost management roles, and addressing governance issues that mirror concerns identified in previous capital project reviews and issues highlighted at the recently issued Capital Governance Advisory Report. The Health Board will now also need to re-engage with the market as previous tender prices are no longer valid.

Image 1: Summary of final report assurance ratings issued as of 31 July 2026 (for 2025/26)¹

Assurance rating applied

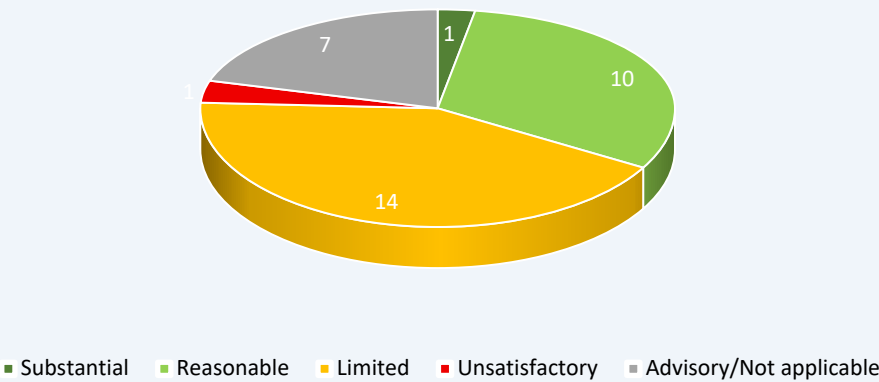


Table 4 details the status of all reviews in the 2025/26 plan.

Follow-up

The Corporate Governance Directorate provides Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure. We have reviewed 75 recommendations, with the outcomes noted in the table below.

Table 2 – Status of follow-up actions submitted for closure

¹ Excludes Sickness Management (BCU-2526-41) and Integrated Audit Plan - Royal Alexandra Hospital Health and Wellbeing Hub (BCU-SSU-2526-46) which have been included in 2026/27 figures.

Recommendation category by submission	Number of recommendations	Closed	Partially closed	Outstanding
Submitted for first review	48	25 (52%)	10 (21%)	13 (27%)
Submitted for further review	27	18 (67%)	7 (26%)	2 (7%)
TOTALS	75	43 (57%)	7 (23%)	15 (20%)

Contingency/Health Board support/Advice

Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.

We have met with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

We have attended and observed the Risk Scrutiny and Executive Policy Oversight Groups in this reporting period, coupled with attending/observing the Health Board and its Committees. We have also provided our advice for the change in process for approving new Oracle users.

We have met with the Director of Corporate Governance in this reporting period.

Delivering the plan

All reviews in the 2025/26 annual plan (except for two that were transferred into 2026/27) have been completed. The status of the 2026/27 plan is detailed in image 2, with further details in Table 6.

Image 2: Status of plan delivery – 2026/27



The additional support provided to the Health Board with focused reviews is channelled through contingency.

As new risks are identified in year, the Director of Corporate Governance and Head of Internal Audit will consider the planned reviews against the emerging high-level risks.

The Audit Committee is requested to approve the changes to the audit plan outlined in the table below.

Table 3: Changes to the 2026/27 internal audit plan

Audit Title	Reason for requesting deferral / removal from plan / adding to the plan
Research & Development (BCU-2627-17)	The Health Board is commissioning an external review into Research and Development arrangements which will be completed in 2026; undertaking a review prior to this does not add value as current internal controls may be impacted by the review. Recommendation: This review is deferred for consideration as part of risk planning for the 2027/28 plan.
Culture (BCU-2627-28)	Following discussion with the Executive Director of Workforce & Organisational Development, we have agreed that this review becomes advisory and not an assurance report. A three-year Culture, Leadership & Engagement Improvement Plan (2026–2029) is in place and is in the early stages of delivery. A mid-year review will support the Executive Director in gauging implementation, in doing so highlighting any gaps in delivery early on. Recommendation: This review is amended from assurance opinion to advisory.

The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5).

For 2025/26, thirty-three reports have been issued as final, with twelve missing the management response timeline.

Table 4 is reporting a positive status across all except one indicator; report turnaround time has improved from 62% to 64% but still remains a challenge. Figures are based on reports issued as final.

Performance for 2026/27 will be reported in the next progress report.

Table 4: Performance Indicators (2025/26)

Indicator	Status	Actual	Target
Operational Internal Audit Plan agreed for 2025/26		4 March 2025	30 June
Total audit reviews reported against adjusted plan for 2025/26		33	35
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100%	95%

Indicator	Status	Actual	Target
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]		64%	85%
Report turnaround: time from management response to issue of final report [10 days]		100%	95%
Key  v>20%  10%<v<20%  v<10% :			

Table 5: Core Plan 2025/26

Planned output	Status	Planned Committee Meeting ²	Assurance rating
1. Risk Management and Board Assurance Framework (Assurance)	Final report.	April 2026	Reasonable
2. Follow up	Complete.	On-going	Assurance Not Applicable
3. Corporate Legislative Compliance - Civil Contingencies Act 2004 (Assurance)	Final report.	October 2025	Limited
4. Standards of Business Conduct (Assurance)	Final report.	August 2026	Limited
5. Executive Committee Governance (Assurance)	Final report.	August 2026	Limited
6. Public Health: Prevention and Early intervention – Grant funded activity (Assurance)	Final report.	October 2025	Reasonable
7. Value and Sustainability – delivering quality improvements (Assurance)	Final report.	October 2025	Limited
8. Budgetary Control and Financial Reporting (Assurance)	Deferred.	-	-
9. Budget Setting (All Wales review) (Assurance)	Final report.	August 2026	Reasonable
10. Patient Experience (Assurance)	Final report.	October 2025	Reasonable
11. Learning – Regulatory reporting (Assurance)	Final report.	October 2025	Limited
12. Outpatient Transformation (Assurance)	Deferred.	-	-
13. Complaints (Assurance)	Final report.	December 2025	Reasonable
14. Skills and Capabilities (Assurance)	Deferred.	-	-
15. Delivering successful change and benefits realisation (Assurance)	Final report.	December 2025	Reasonable
16. Non-Digital Data and Technology (DDaT) controlled IT (Assurance)	Final report.	April 2026	Limited

² Subject to change

Planned output	Status	Planned Committee Meeting ²	Assurance rating
17. Community Services (Assurance)	Final report.	December 2025	Reasonable
18. Productivity and Efficiency (Assurance)	Deferred.	-	-
19. Planned Care Major Change Programme – Governance and Delivery (Assurance)	Final report.	April 2026	Limited
20. Urgent Emergency Care - Implementation of Audit Wales Actions	Final report.	August 2026	Assurance Not Applicable
21. Primary Dental Care (Assurance)	Deferred.	-	-
22. Primary Medical Care – Contract Assurance Framework (Assurance)	Final report.	February 2026	Reasonable
23. Workforce Planning (Assurance)	Deferred		-
24. Culture and Leadership Development – Delivery of priorities (Assurance)	Final report.	April 2026	Reasonable
25. Speaking Up Safely (Assurance)	Final report.	August 2026	Limited
26. On-call arrangements (Assurance)	Final report.	February 2026	Limited
27. Consultant Job Planning follow up	Final report.	October 2025	Assurance not applicable
28. NICE guidance compliance (Assurance)	Final report.	February 2026	Limited
29. Agency utilisation (Assurance)	Deferred.	-	-
30. Challenged Care services (Assurance)	Final report.	August 2026	Limited
31. Estate Management – Estates and Facilities Alerts (Assurance)	Final report.	February 2026	Limited
32. Statutory Compliance: Asbestos Management (Assurance)	Final report.	April 2026	Substantial
33. Capital Systems (Assurance)	Deferred.	-	-
34. Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance)	Deferred.	-	-
35. Integrated Regional Care Fund (IRCF) Projects (Assurance)	Deferred.	-	-
36. Falls Management follow up	Final report.	August 2025	Assurance not applicable
37. Contract management and procurement – Digital Data and Technology (Advisory)	Final report.	August 2025	Advisory
38. Contract management and procurement – Executive and Director corporate functions (Assurance)	Final report.	December 2025	Limited
39. Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (Assurance)	Deferred.	June 2026	-

Planned output	Status	Planned Committee Meeting ²	Assurance rating
40. Pharmacy regulatory compliance	Final report.	August 2026	Limited
41. Sickness management	Carried over to 2026/27	-	-
42. Purchase cards & Petty cash	Final report	August 2026	Reasonable
43. Capital Governance Arrangements	Final report	August 2026	Advisory
44. Centre for Mental Health and Society	Final report.	April 2026	Advisory
45. Integrated Audit Plan – Nuclear Medicine	Final report.	August 2026	Unsatisfactory
46. Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub	Carried over to 2026/27	-	-

Table 6: Core Plan 2026/27

Planned output	Status	Planned Committee Meeting ³	Assurance rating
01. Sickness management – corporate directorates (carry over from 2025/26)	Final report.	August 2026	Reasonable
02. Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub (carry over from 2025/26)	Work progress. in	October 2026	
1. Risk Management and Board Assurance Framework	Not started.	April 2027	
2. Follow up	Work progress. in	On-going	
3. Health and Safety	Work progress. in	October 2026	
4. Foundations for the Future – Project delivery	Work progress. in	October 2026	
5. Foundations for the Future – Operational governance and accountability	Not started.	June 2027	
6. Implementation of Ministerial Directives.	Brief agreed.	December 2026	
7. Integrated Medium Term Plan (IMTP) and Annual Delivery Plan	Work progress. in	October 2026	
8. Accountability and Performance Management	Planning.	April 27	
9. Value and Sustainability – project governance and clinical variation	Brief agreed.	December 2026	
10. Private Practice	Work progress. in	October 2026	

³ Subject to change

Planned output	Status	Planned Committee Meeting ³	Assurance rating
11. Budgetary Control and Financial Reporting	Work progress. in	October 2026	
12. Delivery of Savings	Work progress. in	October 2026	
13. Quality Management System	Not started.	June 2027	
14. Clinical Audit	Planning.	February 2026	
15. Medical Devices	Planning.	April 2027	
16. Commissioned services – specification and performance	Not started.	February 2027	
17. Research and Development	Recommended for deferral.	TBC	
18. Suicide prevention	Work progress. in	October 2026	
19. Skills and Capabilities	Brief agreed.	December 2026	
20. Cyber Security	Work progress. in	October 2026	
21. Service Implementation (ITIL)	Not started.	April 2027	
22. Artificial Intelligence (AI) – governance and control	Not started.	June 2027	
23. Planned Care delivery – validation	Not started.	TBC	
24. Urgent and Emergency Care (UEC) – verifying UEC flow	Not started.	April 2027	
25. Funded nursing and Continuing Health Care	Not started.	February 2027	
26. Primary Dental Care	Not started.	April 2027	
27. Violence and Aggression	Brief agreed.	October 2026	
28. Culture	Not started.	April 2027	
29. Statutory Compliance: Water safety	Not started.	June 2027	
30. Management of leases	Not started.	June 2027	
31. Space Utilisation (Advisory)	Work progress. in	October 2026	
32. Capital Systems - Targeted Estates Fund (TEF)	Brief agreed.	TBC	
33. Integrated Audit and Assurance Plans	Not started.	TBC	

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.

Disclaimer

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

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the 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.

Public Sector Internal Audit Standards

Audit and Assurance Services conform with the Institute of Internal Auditors (IIA's) professional standards and to the Global Internal Audit Standards in the UK Public sector through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Betsi Cadwaladr University Health Board – Audit Committee Update

Date issued: August 2026



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Introduction

This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board (the Health Board). We presented our Audit Plan to the committee in April 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Completed
- **Committee date:** 23rd June 2026.

Audit of the 2025-26 Awyr Las Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2025-26 Audit of Awyr Las Annual Report and Accounts.
- **Status:** Planning work ongoing
- **Expected committee date:** January 2027.

Performance audit update

Deep dive review of the arrangements to manage estates

- **Executive Lead:** Chief Executive Officer
- **Focus of the work:** This work examines the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Report in clearance
- **Expected committee date:** October 2026.

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider:
 - The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
 - The efficacy of local plans and associated actions to recover cancer waiting lists; and
 - Use of the additional Welsh Government financial allocations to improve cancer services.
- **Status:** Report in clearance
- **Expected committee date:** October 2026.

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations.
- **Status:** Planning
- **Expected committee date:** December 2026.

Foundations for the Future

- **Executive Lead:** Chief Executive Officer
- **Focus of the work:** This work will focus on the Health Board's implementation of its organisational redesign and Foundations for the Future operating model. We will review arrangements alongside and as the programme progresses, rather than a single one-off audit.
- **Status:** Planning
- **Expected committee date:** As part of the Annual Audit Summary at the end of this period (April 2027).

Primary Care follow up of recommendations

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will primarily focus on the Health Board's progress implementing the recommendations and areas for improvement identified in my previous [Review of Primary Care](#).
- **Status:** Planning
- **Expected committee date:** February 2027.

Review of the management and prevention of diabetes

- **Executive Lead:** Medical Director
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. The exact focus of this work is still to be determined, but it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.
- **Status:** Planning
- **Expected committee date:** April 2027.

Other relevant publications

Over the past three months, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

<u>NHS urgent and emergency care – a system under pressure</u>	June 2026

<u>NHS planned care – fit for the future?</u>	June 2026

Since the last committee update, Audit Wales has published its Code of Audit Practice.

<u>Code of Audit Practice</u>	July 2026

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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





Audit Committee

ADRODDIAD GWRTH-DWYLL CH1 2026-2027 COUNTER FRAUD Q1 2026-2027 REPORT

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Danielle Kerr-Timmins, Head of Counter Fraud
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Russell Caldicott, Executive Director of Finance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This report provides an overview of counter fraud activity undertaken during Quarter 1 of 2026/27 and highlights progress against the approved annual work plan. During the quarter, the Counter Fraud Team has focused on establishing delivery arrangements for the new financial year, supporting strategic governance, progressing proactive prevention activity, and continuing operational investigations. A revised All-Wales Fighting Fraud Strategy has been developed through the Counter Fraud Steering Group and aligns with the newly published NHS Counter Fraud Authority (NHSCFA) Strategy 2026-2029. The updated strategic framework reflects emerging fraud risks and strengthens the Health Board's commitment to protecting public funds.

The NHSCFA has also published an updated Fraud Vulnerability Overview which identifies NHS Staff Fraud as the most significant area of fraud risk across the NHS, representing over 56% of identified fraud vulnerabilities. In response, the Counter Fraud Team will continue to prioritise preventative activity across workforce-related processes and strengthen engagement with People Services and operational managers.

Progress has also been made with People Services and Assistant Directors in developing a Parallel Investigation Protocol, which will provide a formal framework for

the management of cases involving both employment and fraud-related investigations.

The Committee is asked to:

NOTE progress against the Counter Fraud Workplan for 2026-27.
NOTE the contents of the report.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Russell Caldicott	29/07/2026	Paper presented to Executive Director of Finance for approval – paper approved for Audit Committee

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

NHSCFA – NHS Counter Fraud Authority
NFI – National Fraud Initiative
LCFS – Local Counter Fraud Specialist

1. Y SEFYLLFA / SITUATION

- 1.1 This report provides a high-level overview of counter fraud activity undertaken by the Betsi Cadwaladr University Health Board (BCUHB) Counter Fraud Team during Quarter 1 of 2026/27 and outlines progress against the approved annual work plan for the current financial year.
- 1.2

2. Y CEFNDIR / BACKGROUND

2.1 Performance Dashboard (Public Summary)

Further detail is included within Appendix A (Dashboard).

	Q2 25/26	Q3 25/26	Q4 25-26	Q1 26-27
Open Cases (end of quarter)	19	33	32	22
Cases Closed in quarter	16	0	13	15

Open cases represent a mix of allegations across workforce, patient, and primary-care-related categories.

2.2 Progress Against Annual Work Plan

Quarter 1 has focused on commencing delivery of the approved 2026/27 Counter Fraud Work Plan, which is structured around the four NHSCFA strategic principles of Strategic Governance, Inform & Involve, Prevent & Deter and Hold to Account. All Key Performance Indicator targets have been met.

✓ Strategic Governance

- The 2026/27 Counter Fraud Work Plan received approval through the appropriate governance arrangements and has entered the delivery phase.
- A revised BCUHB Fighting Fraud Strategy has been developed through the Counter Fraud Steering Group.
- The NHS Counter Fraud Functional Standard Return has been prepared and submitted in line with NHS Counter Fraud Authority (NHSCFA) requirements.
- Appropriate accountable officer arrangements remain in place, including the nominated Executive Director, Audit Committee oversight arrangements and Counter Fraud Champion roles.
- Attendance and participation in national and All-Wales Counter Fraud meetings have continued to support intelligence sharing and best practice. The BCUHB Head of Local Counter Fraud has also taken the position of vice-chair of the All-Wales Counter Fraud Liaison Group.

✓ Inform & Involve

- Delivery of the Year 2 Communications Strategy has commenced, including planning for fraud awareness campaigns, Counter Fraud Clinics and digital engagement activity. The first communications and first Counter Fraud Clinic have already taken place.
- Fraud awareness activity has continued through direct engagement with staff across clinical and corporate services.
- Work has commenced with People Services Assistant Directors to finalise a Parallel Investigation Protocol which will improve coordination between employment and fraud investigations.
- Planning has commenced for future delivery of the Counter Fraud Ambassador Programme scheduled within the annual workplan.

✓ Prevent and Deter

- Proactive fraud prevention activity has commenced in line with the workplan objective to undertake one proactive exercise per quarter. The first Local Proactive Exercise has focused on declarations of interest for secondary employment of Consultants.
- Fraud risk reviews continue to be undertaken across identified risk areas.
- Ongoing participation in the National Fraud Initiative (NFI) and national intelligence activity continues. The NFI has identified five matters of potential concern which are being actively investigated, four of which relate to polygamous working or working whilst sick.
- Counter Fraud continues to provide support and advice regarding fraud-proofing controls within organisational policies and procedures.

✓ Hold to Account

- Investigation activity has continued throughout the quarter in accordance with NHSCFA standards.
- New referrals are being assessed and recorded through the CLUE case management system in line with performance requirements.
- Appropriate sanctions, recovery opportunities and prevention recommendations continue to be considered in all investigations concluded during the quarter.

2.3 Strategic Fraud Risk Environment

The NHS Counter Fraud Authority published its new Strategy 2026-2029 during Quarter 1, establishing the national strategic direction for counter fraud activity

across the NHS. The strategy reinforces the importance of prevention, intelligence-led action, organisational resilience and collaborative working to protect NHS resources.

The NHSCFA has also released an updated Fraud Vulnerability Overview identifying thematic fraud risks affecting NHS organisations. The assessment highlights NHS Staff Fraud as the single largest area of risk, accounting for more than 56% of identified fraud vulnerabilities nationally.

The findings support the Health Board's existing focus on workforce-related fraud risks and will inform fraud prevention activity, awareness campaigns and proactive exercises throughout 2026/27.

2.4 Key Achievements in Q1 (Public)

- Commencement of delivery against the approved 2026/27 Counter Fraud Work Plan.
- Development of a revised BCUHB Fighting Fraud Strategy through the Counter Fraud Steering Group.
- Alignment of local priorities with the NHS Counter Fraud Authority Strategy 2026-2029.
- Continued delivery of fraud risk review activity.
- Progression of the Parallel Investigation Protocol with Assistant Directors within People Services.
- Ongoing participation in All Wales and national counter fraud intelligence networks.
- Continued investigation of fraud allegations and delivery of fraud prevention recommendations.
- Recruitment process commenced for the Band 7 Deputy Head of Local Counter Fraud vacancy.

2.5 Forward Look

- Implement the revised Fighting Fraud Strategy.
- Continue delivery of the 2026/27 Counter Fraud Work Plan.
- Finalise and implement the Parallel Investigation Protocol with People Services.
- Progress proactive exercises identified within the annual work plan.
- Develop fraud awareness activity focusing on workforce-related fraud vulnerabilities identified by the NHSCFA.
- Continue delivery of communication and engagement objectives, including Counter Fraud Clinics and awareness campaigns.
- Support the training development of the Counter Fraud Team including working towards membership of the Government Counter Fraud Profession.

-
- Continue work to strengthen organisational fraud resilience through risk assessment and preventative assurance activity.

3. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

3.1 National Risks and Trends – Fraud Vulnerability Review

The updated NHSCFA Fraud Vulnerability Overview identifies NHS Staff Fraud as the most significant fraud vulnerability across the NHS, accounting for over 56% of identified risk exposure. Workforce-related fraud therefore remains a key area of focus for the Health Board, particularly in relation to recruitment, employment, payroll, expenses, sickness management and conflicts of interest. The Counter Fraud Team will continue to work collaboratively with People Services and operational managers to strengthen preventative controls and raise awareness of fraud risks throughout the organisation.

There are no matters for escalation arising from this report.

4. ARGYMHELLION / RECOMMENDATIONS

Gofynnir i'r Pwyllgor:

The Committee is asked to:

- **NOTE progress against the Counter Fraud Workplan for 2026-27.**
- **NOTE the contents of the report.**

5. APPENDICIES

- a. Appendix A - Counter Fraud Dashboard Q4 25-26
- b. Appendix B – Fighting Fraud Strategy

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	     1. building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirement

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption.</i>
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions.</i>
<u>Answadd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answadd?</i> Quality	Galluogwyr Answadd Enablers of Quality All Apply Na	Meysydd Answadd Domains of Quality All Apply

Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Relates to Counter Fraud Team progress therefore no assessment required.
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Open Investigations – End of Q1 26-27

Cases Under Investigation

32

Referrals Received

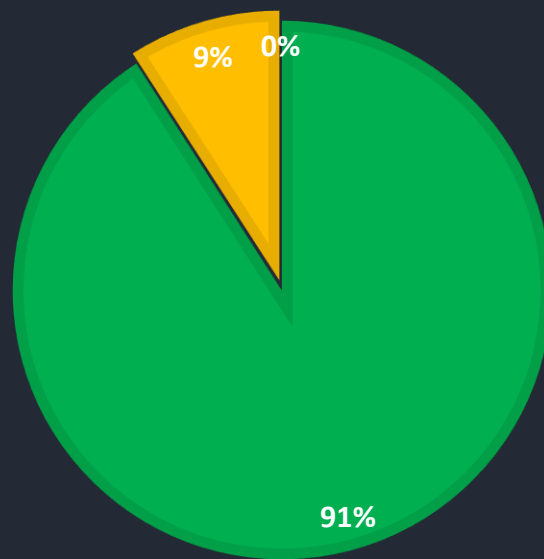
8

Interviews Under Caution

2

PROGRESS SINCE LAST UPDATE

■ Good ■ Acceptable ■ None



Fraud Type	Investigations
NHS Staff Fraud - Employee fraud	21
NHS Staff Fraud - Dental	1
NHS Staff Fraud - General Practitioner	1
NHS Patient Fraud	6
Third Party (external) Fraud	2
NHS Supplier Fraud	1



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Investigation Outcomes – Q1 26-27

Cases Closed

15

Referrals to Other Agency

5

Loss Identified

£10,118.35

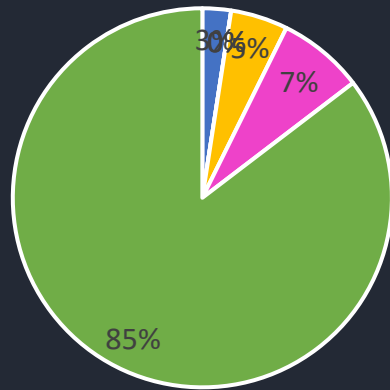
Loss Recovered

£1818.67

Loss Prevented

£32,591.98

SANCTIONS/OUTCOMES



- Disciplinary
- Criminal Prosecution
- Caution/ Community Resolution
- Civil Recovery
- Referral to Other Agency
- DoI Requested

Fraud Identified in
32.7%
Of Cases

Sanctions/Outcomes
Applied
41

Average Days to Investigate
180



Proactive Work – Q1 26-27

E-Learning Training Compliance

91.39%

Risk Reviews

2

Presentations

0

Media Reports

2

System Weakness
Reports Completed

0

Local Proactive
Exercises Completed

1

Local Proactive
Exercises in Progress

2

Engagement Events
(People Seen)

290



Fighting Fraud

**Safeguarding Every Pound
for Patient Care**

**Fighting Fraud Strategy for NHS Wales
2026 – 2030**



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"I am pleased to be able to introduce this second iteration of the Fighting Fraud Strategy, first published in 2019. This strategy reinforces the focus on prevention as Fraud, bribery, and corruption threaten the very resources that keep NHS Wales running. Every pound lost to economic crime is a pound taken away from patient care and therefore this strategy is not just a document—it is a call to action because protecting NHS Wales from economic crime is everyone's responsibility.

The Welsh Government is unequivocal: economic crime against NHS Wales will not be tolerated. It is important to remember that these crimes are not victimless; they undermine trust and steal funding meant for frontline services. Together, we can protect these resources and hold offenders to account.

The approach in NHS Wales is clear:

- *to raise awareness to stop fraud before it starts.*
- *to strengthen controls and systems to prevent it.*
- *to pursue offenders and recover stolen funds for patient care.*

By making best use of intelligence, seeking out innovation and by developing our counter fraud workforce we can stay ahead of evolving risks exploited by criminals. Everyone plays a vital role.

You can make a difference when you:

- **Champion fraud awareness** within your teams and networks.

- **Report concerns promptly—every report matters.**
- **Embed strong controls** in your service area to support prevention.
- **Complete required training and engage with campaigns** to stay informed.
- **Stay vigilant and take proactive action** to reduce the risk of fraud in your area.

Your engagement is vital. A coordinated response which is strategic, tactical, and operational—will ensure NHS Wales is resilient against fraud.

I am proud to champion this work and confident this strategy will deliver real impact. Thank you to our dedicated staff and partners for your commitment to protecting NHS Wales. Together, we can protect the resources meant for patient care. Every action matters. "



Jacqueline Totterdell
Chief Executive, NHS Wales

Executive Summary

Fraud, bribery, and corruption are growing threats that divert vital NHS funds, increase costs, and erode public trust. Every pound lost is a pound taken from patient care.



Our Vision

To build a resilient, intelligence-led, and collaborative counter fraud culture across NHS Wales to ensure resources are protected for patient care.

Our Strategy

Our strategy focuses on proactive prevention, rapid detection, and decisive action to safeguard NHS resources.

- **Prevent fraud before it happens.**
- **Detect and investigate swiftly.**
- **Apply sanctions and recover stolen funds.**
- **Build expertise and capability across NHS Wales.**



How We Will Deliver

- Use intelligence to identify and target fraud risks.
- Raise awareness among staff, patients, and suppliers.
- Act decisively against offenders.
- Invest in staff training, tools, and resources to enhance effectiveness.



In the last five years, NHS Wales has applied 59 sanctions and recovered a total of £3,322,427, returning funds to patient care. Fraud risks are ever evolving—from procurement and contract fraud through to cybercrime—and we must stay ahead.

Fraud is one of the most prevalent crimes in England and Wales, and the National Crime Agency estimates that around 67% of reported fraud is cyber-enabled¹ and the NHS is a prime target. With NHS Wales processing billions of transactions and sensitive data, the stakes have never been higher.

This strategy builds on the previous *Fighting Fraud Strategy (2019)* recognising new and emerging risks. This strategy raises the bar with refreshed objectives and will be underpinned with a delivery plan and measurable indicators. It also aligns with UK-wide counter fraud strategies and Welsh Government priorities.

This strategy is our commitment to safeguarding every pound for patient care. Together, we will make NHS Wales resilient against fraud.

Fraud prevention is everyone's responsibility.

All NHS staff must remain vigilant and report any suspected fraud to their Local Counter Fraud Specialist or NHS Counter Fraud Services Wales.

Strategic Objectives

To protect NHS Wales resources and maintain public trust, we must adopt a proactive and coordinated approach to tackling fraud. Our Strategic Objectives provide the foundation for this work, focusing on prevention, early detection, decisive response, and building the capability needed to stay ahead of evolving risks. By investing in our people, connecting intelligence, and strengthening collaboration with partners across Wales and the UK, we will create a resilient system that protects funding so it can be directed where it matters most—patient care.

Strategic Objective		Description
Prevent		Assess the risk, strengthen systems and controls and promote awareness to stop fraud before it occurs.
Detect		Use data, intelligence and advanced analytics to help prioritise resources and link fraud risks early.
Respond		Investigate thoroughly, recover losses, and apply appropriate sanctions swiftly.
Build Capability		Invest in our people by providing specialist training and equipping counter fraud teams with latest tools and technology.
Collaborate		Foster strong partnerships across NHS Wales, other Welsh public bodies, Welsh Government, and UK agencies such as HMRC and DWP to share intelligence and best practice.

Key Enablers

Delivering our Strategic Objectives requires more than intent—it requires investment in the right tools, skills, and partnerships.

This includes:

- the Welsh Government Directions, which establish the legal framework for the responsibilities and functions of NHS Counter Fraud services across NHS Wales, including requirements for cooperation with partners; and
- the local counter fraud specialists and the national counter fraud service across NHS Wales, whose ongoing and collaborative work -enabled by these Directions - forms a core enabler of effective prevention, detection, and response. Their contribution will be fundamental to delivering the objectives set out below.

To strengthen NHS Wales’ resilience against fraud, we have identified a set of **Key Enablers** that will underpin our approach. These enablers provide the infrastructure, technology, and expertise needed to prevent fraud, detect risks early, respond effectively, and build capability across the system. By aligning each enabler with our objectives, we ensure a clear, coordinated path to success.

Strategic Objective	Key Enabler	Impact
Prevent 	Functional Standards: Benchmarking & Assurance. Counter Fraud Culture: Led from the top, fostering a proactive, NHS-wide culture that empowers everyone to prevent fraud and manage risk effectively. All NHS employees should complete the e-learning Fraud Awareness training module.	Sets clear benchmarks for counter fraud activity and provides assurance that controls are robust and effective and that standards are being met across NHS Wales. Building a strong anti-fraud culture increases awareness and helps identify fraud risks early. Prevention through good practice is the most effective way to reduce fraud in the NHS.

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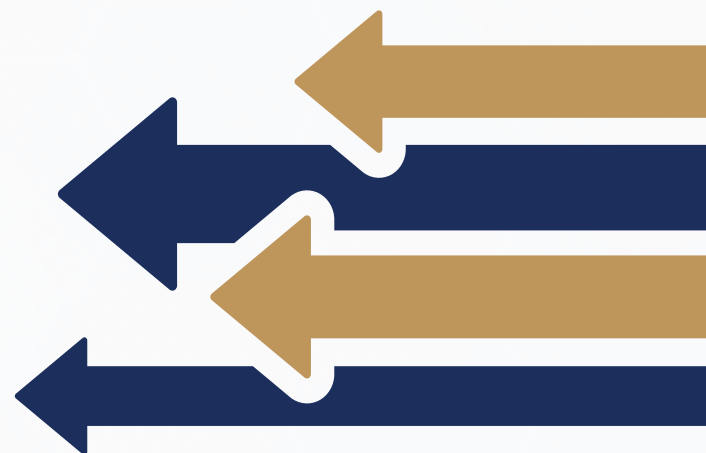
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Strategic Objective	Key Enabler	Impact
Detect 	Encourage all staff and stakeholders to report fraud whenever they have a concern. Collaborative approach to Risk Assessments and use of Data Analytics & AI.	Enables early identification of fraud risks through use of data analytics and AI driven tools to improve intelligence-led decision-making across Wales, enabling a proactive and front-footed response to both existing and emerging threats.
Respond 	Digital Forensics, CLUE System & Proceeds of Crime Act 2002. Investment in investigative resources and training.	Delivers enhanced investigation tools for robust evidence gathering, case management, and recovery of stolen funds.
Build Capability 	Continuous professional development through the Centre for Specialist Learning.	Provides professional development, specialist training, and accreditation to strengthen counter fraud capability and to equip staff with the skills needed to tackle evolving fraud risks.
Collaborate 	Counter Fraud Liaison Group. Counter Fraud Steering Group. Directors of Finance Group.	Promotes operational collaboration, sharing of best practice, and consistency across Health Boards, Special Health Authorities and Trusts.

Priorities for Action

Accountability and progress tracking are central to this strategy. Each Strategic Objective will be monitored against planned actions, with regular reporting to the Counter Fraud Steering Group and Welsh Government. This ensures transparency, drives continuous improvement, and keeps NHS Wales focused on safeguarding resources for patient care.

Together, the following planned actions will create a proactive, coordinated system that safeguards NHS resources and ensures funding is directed to patient care.



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Strategic Objective	Description	What will 2030 and beyond look like
Prevent 	To reduce opportunities for fraud before they arise, we will strengthen assurance frameworks and embed fraud risk management across NHS Wales. We will: • implement annual benchmarking reviews against Functional Standards, • develop local and national assurance dashboards, • implement a process for tracking actions and follow up of national proactive exercises. • undertake fraud risk assessments using a consistent and efficient methodology • publish an annual Counter Fraud Assurance Report. These measures will set clear expectations and provide transparency on progress.	Fraud risk management will be embedded into everyday processes, making it a standard part of governance and decision-making rather than a reactive measure. Staff across NHS Wales will have a clear understanding of fraud risks and their role in mitigating them. Local and national dashboards will provide real-time visibility of fraud risk indicators, enabling quick interventions and informed decision-making.

Detect



Early detection is critical to minimising financial loss and protecting patient care.

We will:

- deploy advanced data analytics and AI-driven tools to identify anomalies in financial transactions,
- integrate fraud risk indicators into core systems,
- establish a central data-sharing protocol to enhance intelligence across NHS Wales.

Quarterly fraud trend analysis will inform proactive interventions and ensure resources are directed where they are most needed.

Predictive models identify emerging fraud risks before they materialise, enabling pre-emptive action.

A secure, NHS Wales-wide data-sharing protocol ensures that intelligence from one health organisation is instantly available to all others.

Patterns of fraud detected in one region inform preventive measures everywhere, creating a network effect of protection.

Respond



When fraud occurs, we must act decisively and recover stolen funds.

We will:

- work with the NHS CFA to enhance the case management system to improve investigation efficiency,
- put in place arrangements for counter fraud specialists to access data analytics expertise,
- implement a rapid response protocol in collaboration with national and local Cyber teams for cyber-enabled fraud incidents.

Recovery methods and achievements will be monitored to ensure accountability and continuous improvement.

The case management system is fully enhanced, enabling investigators to manage cases seamlessly, track evidence, and collaborate across health organisations in real time.

A rapid response protocol is triggered immediately when cyber-enabled fraud is detected—like an emergency response system.

NHS Wales publishes transparent recovery data, reinforcing public trust and demonstrating continuous improvement.

Build Capability



A skilled and knowledgeable workforce is essential to staying ahead of evolving fraud risks.

We will:

- deliver structured CPD programmes,
- introduce career pathways including technician roles and consider secondment opportunities with NHS CFA in areas such as data analytics and digital forensics,
- Require all NHS Wales employees to complete the e-learning fraud awareness module.

Annual Counter Fraud Conferences will provide opportunities to share best practice and emerging trends.

Counter fraud roles have clear career pathways, including technician-level positions and advanced roles in analytics and digital forensics.

The e-learning fraud awareness training is accessible to all NHS Wales employees—from clinical staff to executives. Increased awareness helps to reduce fraud.

Annual Counter Fraud Conferences are major events, bringing together experts, health organisations, and other partners to share best practices and emerging trends.

Collaborate



Fraud prevention and detection require strong partnerships. The Counter Fraud Steering Group will work with Directors of Finance and the Counter Fraud Liaison Group to drive operational collaboration, share intelligence, and promote consistency across Health Boards, Special Health Authorities, and Trusts.

We will:

- strengthen the sharing of intelligence across Wales, between the four nations and other public bodies including police forces,
- publish joint guidance documents,
- and establish cross-organisation arrangements, working with the NHSCFA to tackle high-risk areas such as procurement and cybercrime.

Collaboration is no longer ad hoc—it's structured, consistent, and strategic, ensuring alignment across the entire NHS Wales system.

Enhanced intelligence sharing across the UK and public bodies enabling real-time access to fraud alerts, case updates, and emerging risk patterns. This shared intelligence helps identify cross-organisational trends early, allowing faster and more coordinated action.

NHS Wales publishes standardised guidance documents co-developed by all partners, ensuring consistency in fraud prevention and response.

Key Outcomes by 2030



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Fraud prevention is system-wide, not siloed—intelligence flows freely, and responses are coordinated.

2

NHS Wales is recognised as a leader in collaborative fraud prevention, influencing UK-wide policy.

3

Public confidence is strengthened because the system demonstrates collaboration, transparency, and effectiveness.

Staff Responsibility

Fraud prevention is everyone's responsibility.

All NHS staff must remain vigilant and report any suspected fraud to their LCFS or CFSW.

Governance Structure

Strong governance is essential to ensure accountability, consistency, and effectiveness in tackling fraud across NHS Wales. This governance structure provides a clear line of accountability from local services through to national oversight, ensuring NHS Wales remains resilient against fraud risks and focused on protecting resources for patient care.

Counter Fraud Steering Group (CFSG)

The CFSG provides strategic oversight of counter fraud services across NHS Wales and advises Welsh Government on actions and opportunities for improvement.

Meetings: Quarterly

Chair: NWSSP Director of Finance and Corporate Services

Membership:

- Welsh Government representative
- NHS Wales Finance Directors
- Audit Committee Chairs
- NHS Counter Fraud Authority
- Head of Counter Fraud Services Wales
- Chair of the Counter Fraud Liaison Group
- Audit Wales (Observer)

The CFSG ensures alignment with national priorities, reviews performance, and recommends enhancements to strengthen fraud prevention and detection.



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Counter Fraud Liaison Group

Established in 2025, this group brings together Local Counter Fraud Specialists (LCFS) and NHS Counter Fraud Services Wales. Its primary purpose is peer to peer support and to share best practice, promote consistency, and support operational delivery across Health Boards, Special Health Authorities and Trusts.

Members report direct to their respective Director of Finance and can collectively raise common issues and opportunities through the Directors of Finance Group to raise with the Counter Fraud Steering Group. The Chair and Vice Chair also attend the Counter Fraud Steering Group meetings.

Local Governance

Operationally, local counter fraud specialists report to Finance Directors and are monitored by Audit Committees within each NHS body. These Committees review annual work plans, progress reports, and outcomes to ensure robust oversight and accountability.

The Head of Counter Fraud Services Wales provides professional support, direction and strong leadership to the network of local counter fraud specialists within NHS bodies in Wales as well as operational line management of the NHS Counter Fraud Services Wales team. They advise NHS Wales Directors of Finance and Welsh Government officials, and work in close partnership with the NHS Counter Fraud Authority, National Crime Agency, regional police forces, HMRC, and the Department for Work and Pensions.

Quality Assurance

The quality of counter fraud services within NHS Wales is assessed against the Government Functional Standards 013 Counter Fraud, facilitated by the NHS Counter Fraud Authority (NHSCFA) and adopted across NHS Wales.

These standards ensure that measures to prevent, detect, and respond to fraud, bribery, and corruption are implemented in line with the Cabinet Secretary for Health and Social Services' Directions and the Service Level Agreement between Welsh Government and the NHSCFA.

Purpose of the Standards

The Functional Standards provide a consistent framework to:

- Embed robust counter fraud controls across NHS Wales.
- Ensure compliance with statutory and contractual obligations.
- Deliver transparency and accountability in fraud prevention and detection.



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Quality Assurance Programme

The programme comprises **two core processes**:

1. Assurance

- Each NHS organisation completes an annual self-review against the Functional Standards.
- Results are reported to the NHS organisation's Audit Committee and submitted to the NHSCFA for analysis and thereafter to the UK Government.
- This process ensures compliance, highlights areas for improvement, and supports continuous development.

2. Assessment

- The NHSCFA Quality and Compliance team conducts independent assessments.
- Using the Self-Review Tool, supporting evidence, and inspection procedures, the team evaluates:
 - **Counter fraud resources.**
 - **Performance against standards.**
 - **Effectiveness of implemented controls.**
- Any recommended improvements should be addressed promptly, to maintain high standards and strengthen capability.

Governance Reviews

In addition to above Quality Assurance Programme the Counter Fraud Service Wales (CFSW) team undergoes a cyclical governance assurance review conducted by the NHSCFA, ensuring alignment with national standards and best practice.



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Resources to support Counter Fraud Arrangements in NHS Wales

Local Counter Fraud Specialists

The Welsh Government Directions on Counter Fraud require every Health Body to appoint qualified Local Counter Fraud Specialists (LCFS), accredited by the Counter Fraud Professional Accreditation Board or equivalent. There are 23.38 whole time equivalent (WTE) LCFS staff in Wales, all directly employed by NHS bodies.

LCFS act as the primary point of contact for all economic crime concerns within their organisation. They agree annual work plans with their Health Body, balancing proactive activities (fraud awareness, risk assessment and detection) and reactive work (investigations), aligned to the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

NHS Counter Fraud Services Wales (CFSW)

The NHS Counter Fraud Service Wales is an independent team funded by Welsh Government and employed by the NHS Wales Shared Services Partnership (NWSSP) hosted by Velindre University NHS Trust. It provides a specialist independent investigation resource to all health bodies in Wales and provides operational oversight on all counter fraud activities in NHS Wales, to ensure compliance with the Welsh Government Directions.

CFSW serves as the professional and strategic lead for NHS Wales on proactive and investigative counter fraud matters, promoting a consistent, high quality approach across health bodies in line with relevant legislation. Its experienced, accredited investigators manage large and complex economic crime cases, provide specialist guidance to the LCFS network, and are authorised to exercise financial investigation powers under the Proceeds of Crime Act 2002.

Specialist Support from NHS Counter Fraud Authority (NHSCFA)

Under a Section 83 Government of Wales Act 2006 arrangement, NHSCFA provides specialist operational support services to NHS Wales, including Forensic Computing and Specialist Dental Services, funded via an annual Service Level Agreement with Welsh Government.

Other Key NHS Wales Functions Supporting Counter Fraud

- **Primary Care Services (PCS):** The Post Payment Verification (PPV) team check claims in General Medical, Ophthalmic, and Pharmacy services. Dental checks are delivered via NHS England Business Services Authority. These checks ensure claims are accurate and services meet NHS specifications. Any concerns are referred to LCFS or CFSW under an Information Sharing Protocol.
- **Audit & Assurance:** NWSSP Audit & Assurance provides internal audit services to all NHS bodies. While not directly responsible for detecting fraud, their work highlights control weaknesses and potential breaches. They collaborate with LCFS under an Information Sharing Protocol.
- **Auditor General for Wales:** External audits may uncover system weaknesses or fraud indicators. Regular liaison occurs between auditors, NHS bodies, Welsh Government and CFSW to address concerns.
- **National Fraud Initiative (NFI):** Led by the Auditor General under statutory powers, NFI matches data across public bodies every two years to identify anomalies. Since inception, NFI has uncovered £56.5M in fraud and overpayments across Wales, including £7.1M in the latest exercise.



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Reporting Fraud

Report NHS fraud securely and confidentially by using the [**NHS Counter Fraud Authority online reporting tool**](#) or by calling our free phone line on 0800 028 40 60.

Contact Details

NHS Counter Fraud Service Wales
1st Floor
Block B
Mamhilad House
Mamhilad Park Estate
Pontypool
NP4 0YP





Audit Committee

CENTRE FOR MENTAL HEALTH AND SOCIETY (CFMHAS) INTERNAL ADVISORY REVIEW AND WIDER RESEARCH, DEVELOPMENT AND INNOVATION REVIEW

Dyddiad y Cyfarfod Date of Meeting	18 August 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Carol Shillabeer, Chief Executive
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Carol Shillabeer, Chief Executive
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol Executive Summary

The Health Board has received extensive correspondence, supporting information and contextual material from individuals who have sought to highlight concerns regarding the arrangements for the Centre for Mental Health and Society (CfMHaS). As Accountable Officer, the Chief Executive has ensured that these matters have been given careful independent consideration and that appropriate enquiries have been undertaken through the relevant governance, audit, counter fraud and assurance processes.

The Audit Committee is provided with an overview of the Internal Audit Advisory Review of the work of the Health Board in association with the Centre for Mental Health and Society, the key findings and recommendations arising from that review, the management response to date, and the wider action now being taken through the commissioned external review of Research, Development and Innovation across the Health Board.

The report contains a Chief Executive Summary Assessment, an overview of the Advisory Review findings and a summary of key risks, current controls and assurance.

Audit Committee members are asked to:

1. **Note** the Chief Executive Assessment that relates to the findings of the Internal Audit Advisory Review of the Centre for Mental Health and Society and the important governance, financial control, value for money and assurance issues identified.
2. **Note** the management actions already completed or in progress, including financial reconciliation, strengthened invoice approval controls, declaration of interest compliance work, honorary contract review arrangements, and review of the Academic Partnership Board Terms of Reference.
3. **Recognise** that several of the agreed management actions are dependent on the wider external review of RD&I, which is now being commissioned and will include CfMHaS as a defined line of enquiry.
4. **Seek assurance** that interim controls remain in place pending the conclusion of the wider review, particularly in relation to invoice approval, duplicate funding checks, declarations of interest, honorary contracts, and future contractual or partnership arrangements.
5. **Request** that the resulting improvement plan from the wider RD&I review is reported back through the appropriate governance route, with clear ownership, milestones, target dates and residual risk assessment.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Audit Committee (in private)	17 February 2026	The Advisory Review was received in a private agenda item of the Audit Committee with a request to bring back with a management response.
Executive Committee	11 March 2026	Support the requirement for the draft management response to the Advisory Review to be confirmed as a matter of priority, with the approval of Lead Executive Directors. Support the establishment of a Task and Finish Group, with the support of appropriate Health Board colleagues to deliver the response.
Executive Committee	11 February 2026	Noted/considered the draft Advisory Review.

		Noted the requirement to complete the factual accuracy check and gain Executive Lead sign off.
Audit Committee	19 August 2025	Provided a briefing related to the procurement of an Independent Review into the Health Board arrangements for CfMHaS.
Audit Committee	5 November 2024	Received the report on the details of an internal review addressing the Freedom Of Information request raised.

Acronymau / Rhestr Termau
Acronyms / Glossary of Terms

CfMHaS	Centre for Mental Health and Society
NWAAS	NHS Wales Audit and Assurance Services
NWSSP	NHS Wales Share Services Partnership
CFS Wales	Counter Fraud Services Wales
LCFS	Local Counter Fraud Services
RD&I	Research Development and Innovation

CENTRE FOR MENTAL HEALTH AND SOCIETY – INTERNAL ADVISORY REVIEW AND WIDER RESEARCH, DEVELOPMENT AND INNOVATION REVIEW

1. Y SEFYLLFA SITUATION

- 1.1 The Health Board has had an agreement with Bangor University since July 2012 and provides grant funding to support the research work of the Centre for Mental Health and Society (CfMHaS).
- 1.2 The purpose of this report is to provide an independent assessment of the work relating to the Centre for Mental Health and Society in the context of the wider organisational improvement journey. The Audit Committee is provided with an overview of the Internal Audit Advisory Review of the work of the Health Board in association with the Centre for Mental Health and Society, the key findings and recommendations arising from that review, the management response to date, and the wider action now being taken through the commissioned external review of Research, Development and Innovation across the Health Board. The external review Terms of Reference confirm that the review is intended to provide an independent, evidence-based assessment of the current state of Research Development & Innovation (RD&I) in BCUHB, including governance, clinical safety, financial performance, research portfolio, supporting infrastructure, and prioritised deliverable recommendations.
- 1.3 The report provides an overall assessment of the position and describes the criticality of the actions arising from the CfMHaS review and the wider RD&I review now being commissioned under the Executive Medical Director.
- 1.4 The Internal Audit Advisory Review considered the arrangements between BCUHB and Bangor University in relation to the Centre for Mental Health and Society. The scope of the Internal Audit review included a historical assessment of the Health Board's contribution and resultant benefits, current and future arrangements between BCUHB and Bangor University, value for money, proposals for future arrangements, and the legal or constitutional arrangements relating to CfMHaS.
- 1.5 The Internal Audit Advisory Review report records that the current arrangement between Bangor University and the Health Board was agreed on 5 July 2012 and had not been subject to formal review since, with undocumented changes evident since the agreement was signed. It also records that the number of posts recharged to the Health Board had increased without evident justification, resulting in increased costs to the Health Board.

- 1.6 The wider organisational context is, however, material. Work that has been undertaken in the last 3 years has indicated a number of issues relating to the establishment and management of contracts in the health board. Significant work has been undertaken in recent years to make systemic improvements in contract management, with positive results. BCUHB is currently subject to Level 5 special measures and has been under heightened scrutiny since 2023 as part of demonstrating sustained organisational improvement.

2 **Y CEFNDIR** **CHIEF EXECUTIVE SUMMARY ASSESSMENT AND OVERVIEW OF THE** **INTERNAL AUDIT ADVIORY REVIEW FINDINGS**

2.1 The Commissioning of the Review:

The Committee will be aware that concerns relating to these arrangements have been raised over several years through a variety of channels. In response, the Health Board recognised the need for an independent review and agreed a detailed Terms of Reference. However, despite a number of attempts through a public procurement route, the organisation was unable to secure a suitably qualified external organisation or individual with the necessary expertise and independence to undertake what was recognised as a complex review involving financial management, research governance, contractual arrangements, procurement, academic partnerships and organisational governance. There was a significant delay due to the withdrawal of a suitably qualified individual at a late stage due to personal reasons. The commissioning process took significantly longer than anticipated and this has added delay to the need to identify and improve arrangements. However, the Health Board was keen to ensure that any review undertaken would be sufficiently independent, credible and robust.

Following discussions with the Chair and Vice Chair, it was agreed that NHS Wales Audit and Assurance Services (NWAAS) should undertake the review through the Head of Internal Audit. The Accountable Officer is satisfied that the review has been undertaken independently, objectively and in accordance with the Internal Audit Charter, Public Sector Internal Audit Standards and the agreed Terms of Reference. In addition she is equally satisfied that the report represents a robust assessment of the arrangements and provides a sound basis upon which the Health Board can address the issues identified and determine future arrangements.

2.2 Chief Executive Summary Assessment



The Internal Audit Advisory Review identifies a number of significant weaknesses in the historical governance, oversight, performance management and assurance arrangements associated with the Centre for Mental Health and Society. Whilst these findings require specific corrective action, it is important that they are considered within the broader organisational context.

Many of the issues identified are not unique to CfMHaS. Rather, they are consistent with challenges that have been experienced across parts of the organisation over a number of years, including weaknesses in documentation, contract management, performance reporting, benefits realisation, accountability frameworks and the maturity of corporate oversight arrangements. These are issues that have featured in a range of reviews undertaken during the Health Board's period in special measures and reflect the legacy of organisational instability, structural change and inconsistent governance arrangements that have existed across a number of functions.

The Committee should therefore view the findings not simply as a review of one partnership arrangement, but as an example of the broader challenges that can arise where long-standing arrangements are not subject to regular review, where expectations and outcomes have not been sufficiently articulated, and where assurance mechanisms have not evolved in line with contemporary governance requirements. The fact that the agreement remained substantially unchanged since 2012 and was not subject to formal review illustrates this point.

It is equally important to recognise that the review does not conclude that research activity undertaken through CfMHaS lacked merit or value. Rather, Internal Audit concluded that the Health Board was unable to demonstrate value for money, expected benefits and appropriate oversight through the evidence available. The central issue is therefore one of governance, assurance and demonstrable benefit rather than the legitimacy of research activity itself.

The Executive has deliberately chosen not to respond to these findings through a narrow or localised action plan alone. Instead, the findings have informed the commissioning of a wider independent review of Research, Development and Innovation across the Health Board. This reflects a view that the issues identified are systemic in nature and that a whole-system assessment is required to establish whether similar weaknesses exist elsewhere, determine the standards the organisation should be working towards, and create a sustainable governance framework for research and innovation that is aligned with the requirements of WHC/2023/026 and the expectations of an organisation seeking to demonstrate sustained improvement.

Whilst progress has been made in addressing the immediate findings, the wider lesson for the organisation is the need to continue strengthening the disciplines of governance, accountability, performance management and benefits realisation across all areas of activity. The CfMHaS review should therefore be viewed as part of BCUHB's broader organisational improvement journey rather than as an isolated issue. The actions being taken through the wider RD&I review provide an opportunity not only to address the specific findings identified but also to embed stronger organisational practices that support transparency, stewardship of public resources and demonstrable benefit for the population of North Wales.

Progress will be monitored through the Health Board's governance arrangements and reported to Audit Committee until the agreed actions have been completed.

2.3 Overview of the Internal Audit Advisory Review Findings

The Internal Audit Advisory Review identified seven high-priority findings across finance management and control, governance, performance monitoring and strategy. The report records that the review identified significant financial contributions by the Health Board and its Charity to CfMHaS since inception in 2012 (over 14 years), estimated at £4,292,733. It breaks that down in relation to revenue funded cost to the Health Board in supporting CfMHaS through invoice recharges and direct budget funding was estimated at £4,134,948 since 2012/13, and a Betsi Cadwaladr Charitable Fund contribution of £157,785 for years one to three.

The Internal Audit report concluded that the Health Board could not demonstrate that it had achieved value for money from the Agreement, citing insufficient evidence of efficiency, effectiveness or direct benefit to the North Wales population. It also identified a potential risk of duplicate funding, noting that CfMHaS recorded eight projects as funded by the Health Board and that the MHLA recharge may also have been used to support the same projects. It is important to note, however, that in a research context, securing value for money is interpreted differently from other contracts for example for goods or services.

The report also identified weaknesses in honorary contract arrangements, including absence of a central register or clear record keeping, and inability to locate job plans for honorary consultant psychiatrists. It further noted that not all staff associated with CfMHaS had up-to-date declarations of interest, increasing the risk of unintentional conflicts of interest for staff holding dual academic and healthcare roles.

The Internal Audit work also found that the Agreement lacked predetermined metrics, outcomes, performance measures and quality indicators, meaning

the Health Board could not evidence whether the benefit of the Agreement had been realised or continued to be realised. The report described this as a significant omission and not reflective of expected governance controls. It is important however to discern that research activity is to explore and test hypotheses, i.e. that it cannot and should not be assumed that direct outcomes, metrics and results could be predicted.

2.4 Wider Research Development & Innovation Review

The wider RD&I review is the principal mechanism through which the Health Board will address the broader implications of the Internal Audit findings. The review is being commissioned by the Executive Medical Director to provide independent assurance on the current position, identify risk and improvement priorities, and inform a credible RD&I strategy and governance model fit for an organisation operating under special measures.

The scope of the review is deliberately broad. It includes governance, leadership and accountability; clinical safety; financial performance and sustainability; commercial activity; non-commercial activity; research impact and value for money; research pipeline and infrastructure; workforce and academic partnership; innovation; public involvement, communications and engagement; and CfMHaS as a line of enquiry within those domains.

The Terms of Reference also confirm that CfMHaS will be considered in relation to the governance and value for money questions raised by the Internal Audit Advisory Review, including whether the population of North Wales receives value from BCUHB's funding, the requirement for a whole-system R&D review, compliance with WHC/2023/026, academic partnership arrangements with Bangor University, the case for wider academic partnerships, and integration of mental health research into the corporate RD&I agenda.

The review methodology includes documentary review, structured interviews and focus groups, site familiarisation, benchmarking, and triangulation of emerging findings with the Steering Group. The Terms of Reference require the reviewer to assess the standard of excellence BCUHB should be working towards, current strengths, weaknesses and gaps, risks and consequences if these are not addressed, and the changes required, including activities to commence or cease.

The review is commissioned by and reports to the Executive Medical Director. A Steering Group will oversee the review, provide access and challenge, and receive the reviewer's outputs; however, the Steering Group will not direct the reviewer's findings, which remain independent.

2.5 Assurance route and reporting

The Terms of Reference state that the final RD&I review report will be addressed to the Executive Medical Director, who will route the report and a summary to the Chief Executive, Executive Team, Quality, Safety and Experience Committee and where appropriate reporting through to Board.

The resulting improvement plan will be owned and monitored by the RD&I Steering Group, with progress reported to the Executive Medical Director and onward to Committee as required. Accepted recommendations will be tracked through a single action plan with named owners and target dates and integrated with the BCUHB risk register where residual risk warrants.

The Terms of Reference also state that the review's findings on excellence in RD&I will inform the next BCUHB RD&I Strategic Plan and associated Implementation Plan.

2.6 Concerns regarding the appropriateness of financial transactions

The Committee will also be aware that some individuals who raised concerns regarding the Centre for Mental Health and Society have characterised aspects of the arrangements as potential fraud. The Health Board has taken these concerns seriously and has ensured that they were considered through the appropriate governance and counter fraud arrangements.

The advice received from the Head of Counter Fraud was that the matters identified were more appropriately characterised as issues relating to governance, financial management, contract management and value for money rather than evidence of fraud. As Accountable Officer, I have carefully considered and accepted that professional advice.

The conclusion and recommendation from that statement provided by the Head of Counter Fraud is attached for completeness (Appendix 1). Based on the evidence available, the findings of the review, and the advice received from Counter Fraud Services, I have not identified evidence that would require any additional intervention outside the Health Board's established governance, audit, assurance and management processes. However, should any new evidence or material information emerge in the future, the Health Board would reconsider the matter and take any further action or make any further referrals deemed necessary.

2.7 Conclusion

The Internal Audit Advisory Review has raised material issues concerning the governance, financial control, performance management and value for money of the historical CfMHaS arrangements. The findings are significant because they relate not only to one academic partnership but to the Health Board's wider ability to demonstrate robust stewardship of public money, clear accountability for research activity, compliance with relevant frameworks, and measurable benefit for the population of North Wales.

The Health Board has made progress in responding to the immediate findings. Financial reconciliation has been completed, interim invoice controls have been strengthened, declarations of interest are being addressed, honorary contract governance is under review, and the Academic Partnership Board's Terms of Reference have been reviewed.

The most important next step is the wider external review of RD&I. That review must provide the independent assurance, evidence base and recommendations required to move from issue-specific corrective action to a coherent Health Board-wide RD&I governance and improvement framework. The Audit Committee should maintain oversight of the residual risks during the review period and seek clear evidence that interim controls remain effective until the final review and associated improvement plan are completed.

3 **MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

3.1 **The Audit Committee is asked to consider the following:**

That the Committee should draw assurance from the fact that:

Immediate compliance and control issues identified by Internal Audit are being addressed through management action plans.

Financial reconciliation work has been completed and enhanced controls introduced around expenditure approval.

A Health Board-wide review of Research, Development and Innovation has been commissioned to address the wider systemic issues identified through the Internal Audit review.

The Committee should note, however, that a number of risks cannot be fully closed until completion of the wider independent review. The most significant residual risks relate to:

1. Demonstrating value for money and population benefit.
2. Establishing a sustainable future governance model.
3. Strengthening performance measurement and benefits realisation.

4. Ensuring full integration of research and innovation into the Health Board's corporate governance and strategic planning arrangements.

That the inability to secure an external review through a procurement process led to a prolonged period of time before the matters raised by individuals were able to be reviewed or considered by this Committee. This report indicates that the Internal Advisory Review has been undertaken independently, objectively and in accordance with the Internal Audit Charter, Public Sector Internal Audit Standards and the agreed Terms of Reference. This has led to key findings and a management responses that address the concerns raised. In particular, through a comprehensive commercial and governance review of the agreement, supported by Finance, NWSSP Procurement Services and executive leadership and immediate action to secure appropriate declarations of interest.

The advice received from the Head of Counter Fraud (and the Accountable Officers subsequent review of that advice) that outline that the matters identified were more appropriately characterised as issues relating to governance, financial management, contract management and value for money rather than evidence of fraud.

4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION, CURRENT CONTROLS AND ASSURANCE

Risk Area	Historic Issue Identified	Current Position	Residual Risk	Key Mitigation
Governance and Accountability	Long-standing arrangements had not been formally reviewed since 2012. Roles, responsibilities, oversight arrangements and performance expectations were insufficiently defined.	Governance arrangements have been reviewed and the wider RD&I review has been commissioned to establish a consistent governance framework across all research activity.	Medium	Independent external review to establish future governance model, accountabilities and reporting arrangements.
Value for Money and Benefit Realisation	Internal Audit concluded that the Health Board could not demonstrate	Financial reconciliation work has been completed and improved	High	RD&I review to establish an agreed framework for measuring

Risk Area	Historic Issue Identified	Current Position	Residual Risk	Key Mitigation
	value for money because expected outputs, benefits, outcomes and performance measures had not been clearly defined or routinely evaluated.	monitoring arrangements are being developed; however a comprehensive assessment of impact and benefit remains outstanding.		research impact, benefits realisation and value for money across the Health Board.
Financial Stewardship and Duplicate Funding	Audit identified concerns regarding documentation supporting expenditure and potential duplication of funding streams.	Financial mapping and reconciliation have been completed. Enhanced approval arrangements now require senior officer sign-off and assurance that duplicate funding is not occurring.	Low-Medium	Continued application of strengthened financial controls pending completion of wider review.
Honorary Contract Governance	No central register of honorary contracts and inconsistent documentation of consultant-level arrangements.	New policy arrangements are being developed, supported by a task and finish group and establishment of a central register.	Medium	Implementation of new policy, ESR recording process and assurance checks.
Standards of Business Conduct	Incomplete declaration of interest compliance for some individuals associated with CfMHaS.	Review and compliance exercise completed with ongoing oversight through Corporate Governance.	Low	Annual compliance monitoring and strengthening of declaration requirements for academic and honorary appointments.
Research Strategy and Organisational Integration	Internal Audit identified that the research activity under review	A whole-system RD&I review has now been commissioned	Medium-High	Delivery of the external review and implementation

Risk Area	Historic Issue Identified	Current Position	Residual Risk	Key Mitigation
	appeared to operate separately from the wider organisational RD&I agenda.	specifically to address this issue and ensure alignment with WHC/2023/026.		of a single corporate RD&I strategy and governance framework.

5 ARGYMHELLION RECOMMENDATIONS

Members are asked to:

- Note** the Chief Executive Assessment that relates to the findings of the Internal Audit Advisory Review of the Centre for Mental Health and Society and the important governance, financial control, value for money and assurance issues identified.
- Note** the management actions already completed or in progress, including financial reconciliation, strengthened invoice approval controls, declaration of interest compliance work, honorary contract review arrangements, and review of the Academic Partnership Board Terms of Reference.
- Recognise** that several of the agreed management actions are dependent on the wider external review of RD&I, which is now being commissioned and will include CfMHaS as a defined line of enquiry.
- Seek assurance** that interim controls remain in place pending the conclusion of the wider review, particularly in relation to invoice approval, duplicate funding checks, declarations of interest, honorary contracts, and future contractual or partnership arrangements.
- Request** that the resulting improvement plan from the wider RD&I review is reported back through the appropriate governance route, with clear ownership, milestones, target dates and residual risk assessment.

ASESIAD / ASSESSMENT

Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Intentions	4.Create a Modern, People Centred Healthcare System
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	The risks associated with this report align to the Corporate Risk Register, including risks relating to statutory compliance (financial and planning duties), financial sustainability and governance effectiveness.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report presents a retrospective review of arrangements related to the CfMHaS. It does not introduce new policies or decisions requiring an equality impact assessment. Consideration of equality impacts is embedded within the operational activities and decisions reported
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report does not represent a strategic decision-making process but reflects activity already undertaken. Socio-economic considerations form part of the underlying

		research that is referenced in the report.
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report does not represent a strategic decision-making process but reflects activity already undertaken. Socio-economic considerations form part of the underlying research that is referenced within the report.
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	No specific human rights impacts arise from the preparation of this report. Human rights considerations are inherent in the delivery of healthcare services and are reflected within the content of the report.
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report does not represent a change in service delivery.
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality All Apply Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	The report provides a retrospective assessment of research undertaken by the Centre for Mental Health and Society rather than introducing new service changes.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable This report reflects activity delivered during the reporting period and does not constitute a new strategic decision requiring assessment against the wellbeing goals.	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	The preparation of this report does not have a direct environmental or sustainability impact.
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	The report does not involve the processing

Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	If no, please include rationale:	of personal data requiring a DPIA.
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ The report contains consideration of the impacts of counter fraud impacts
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below) It is important to the reputation of the Health Board that it can demonstrate that it takes action where concerns have been raised.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Appendix 1 – Statement received from Head of Counter Fraud Wales. (Recommendation and Conclusion)

Recommendation

In the professional opinion of Counter Fraud Service (CFS) Wales, this appears to be a matter of concern related to the effectiveness of the Health Boards ongoing agreement with the University, with limited evidence that the arrangement delivered value for money, rather than a fraud matter. Multiple invoices from Bangor University for the reimbursement of salaries under the agreement were routinely approved for payment by BCUHB without clear explanation of the increased resources claimed and without supporting information.

The initial agreement with Bangor University was for a five-year term commencing on 05.07.2012 and was to continue thereafter unless terminated by either party on three months' notice. Appropriate contract scrutiny and invoice monitoring do not appear to have taken place at BCUHB, and the contract has effectively continued without sufficient review or challenge.

Conclusion

There is no evidence of intentional dishonesty and, in the circumstances, no realistic prospect of a successful investigation or prosecution. CFS Wales therefore considers that this matter is not suitable for criminal investigation in light of the evidential deficiencies identified.

Relevant considerations include the substantial period that has elapsed since members of the public first raised these matters with multiple individuals, including the Local Counter Fraud Services (LCFSs) at BCUHB; the absence of supporting documentation dating back to 2012; and the lack of reliable evidence from key witnesses who are no longer employed by BCUHB.

In summary, having regard to the information set out in the Internal Audit report and the evidential issues identified, this does not appear to be a fraud matter. Should further reliable evidence emerge, CFS Wales will review that information and reconsider this opinion.

It is also recommended that the research contract with Bangor University be reviewed as a matter of urgency and that due consideration be given to the associated BCUHB funding.

Cheryl Hill

Deputy Head of NHS CFS Wales

04/06/2026

Centre for Mental Health and Society (CfMHaS)

Internal Audit Report 2025/26

Advisory Review

Betsi Cadwaladr University Local Health Board

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Review Reference

BCU-2526-44

Fieldwork

October 2025 – January 2026

Executive Sign Off

20 March 2026

Audit Committee

April 2026

Executive Lead

Pam Wenger, Director of Corporate Governance

Audit Team

Dave Harries, Head of Internal Audit

Executive Summary

Purpose

The scope of this review was set by the Health Board to consider the following areas:

- To undertake a historical assessment of the contribution and resultant benefits from entering into this collaboration.
- To consider the current and future arrangements in place between BCUHB and Bangor University in relation to the CfMHaS (this should include a review of the clarity in terms of the services provided, the roles and responsibilities, the performance management arrangements and adherence to quality standards).
- Assess and determine the value for money of these arrangements including the benefits of the arrangements for the Health Board and the wider population (in accordance with the documentation in place between the two parties).
- Assess and evaluate the proposal for future arrangements with the CfMHaS that are referenced in the "SBAR" that the Medical Director of Mental Health and Learning Disabilities (MHLD) has developed and make any suggestions thereafter.
- Make recommendations on the legal requirements for the constitutional arrangements for the Centre for Mental Health and Society, assess how these are currently being met, and any subsequent recommendations for improvement.

Overview

The current arrangement between Bangor University and the Health Board was agreed by both parties on 5 July 2012 and has not been subject to formal review since, with undocumented changes evident since the agreement was signed. The number of posts recharged to the Health Board has increased without evident justification, resulting in increased costs to the Health Board; however, we recognise these have been approved for payment in line with the Scheme of Reservation and Delegation, although these were approved individually and not via a blanket order, with an annual figure, that would have required additional approval and scrutiny.

The Health Board did not take the opportunity, after the initial sixty (60) month agreed period (in 2017), to revisit the Agreement to ensure it remained fit for purpose and delivered value.

We recognise that the MHLD Medical Director has developed a proposal to amend this Agreement, but this is yet to be progressed. Proposals for future arrangements (as outlined in the SBAR) aim to address some financial and operational shortcomings, such as enabling recharging for research time. However, these proposals do not fully address all requirements of the latest Welsh Health Circular *NHS framework for research and development*, nor do they consider alternative academic partnerships.

A comprehensive, system-wide review of research and development within the MHLD Division should be considered, to ensure compliance, optimal value and that MHLD does not operate in isolation.

We have identified several areas where compliance with the Health Board's Standing Financial Instructions is not evidenced.

The Health Board and its Charity have made significant financial contributions to the CfMHaS since its inception, amounting to an estimated £4,292,733.

We have estimated that the revenue funded cost to the Health Board in supporting the CfMHaS, through the invoice recharges and direct budget funding it incurs (staff support and non-staff costs) is £4,134,948 since 2012/13; the Betsi Cadwaladr Charitable Fund contribution of £157,785 for years one to three as per the charitable fund request.

The Health Board cannot demonstrate that it has achieved value for money from the Agreement. There is insufficient evidence of efficiency, effectiveness, or direct benefit to the North Wales population.

There is a potential risk of duplicate funding by the Health Board. Our review identified that the CfMHaS recorded eight projects as funded by the Health Board, with the possibility that the MHLD recharge may have also been utilised to support these same projects.

From the evidence reviewed, the process for awarding honorary contracts is not robust. There is no central register or clear record-keeping for honorary appointments, and we could not locate job plans for honorary consultant psychiatrists.

Not all staff associated with CfMHaS have up-to-date declarations of interest. This gap increases the risk of unintentional conflicts of interest, especially for those holding dual academic and healthcare roles.

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

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 To undertake a historical assessment of the contribution and resultant benefits from entering into this collaboration.		Advisory
2 To consider the current and future arrangements in place between BCUHB and Bangor University in relation to the CfMHaS (this should include a review of the clarity in terms of the services provided, the roles and responsibilities, the performance management arrangements and adherence to quality standards).		Advisory
3 Assess and determine the value for money of these arrangements including the benefits of the arrangements for the Health Board and the wider population (in accordance with the documentation in place between the two parties).		Advisory
4 Assess and evaluate the proposal for future arrangements with the CfMHaS that are referenced in the "SBAR" that the Medical Director of Mental Health and Learning Disabilities has developed and make any suggestions thereafter.		Advisory
5 Make recommendations on the legal requirements for the constitutional arrangements for the Centre for Mental Health and Society, assess how these are currently being met, and any subsequent recommendations for improvement.		Advisory

Management Actions

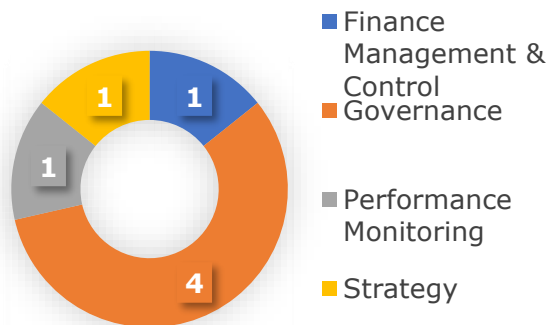


High Priority



Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance
Financial Loss

Findings & Agreed Action Plan

Objective 1: To undertake a historical assessment of contribution and resultant benefits from entering into this collaboration.

Advisory

Overview / Summary of Observations

The Health Board and the Betsi Cadwaladr Charity (the Charity) have contributed financially from the inception of the North Wales Institute for Research in Mental Health and Society (name on the Charitable Fund application made in 2011) and its successor, the CfMHaS.

Payments

The Charity approved "...*pump priming for the development of multidisciplinary research institute...*" totalling £173,109 from its General Fund and reimbursed on an actual cost basis for the period of three years. We were advised by the Charity Accountant on 22 October 2025 it had reimbursed a total of £157,785 (fees for year one, two and three for a professor and web site design with invoices submitted in 2013, 2014 and 2015).

We obtained details from the Finance Directorate of invoices paid by the Health Board to Bangor University for April 2012 to March 2023; the total paid is noted as £2,425,276 (we have not corroborated the information). Using QlikSense, we interrogated requisitions approved for the period April 2023 to September 2025 and identified £762,232 being approved for payment by requisition. The total amount paid/committed is £3,187,508.

Our review of a sample of invoices received in 2025/26 found no details included as to the project/work being undertaken and recharged; it is unclear what services the Health Board are receiving and paying for, and how beneficial it is to the population of North Wales. We are unable to confirm that Standing Financial Instruction 10.3.1 (e) is complied with, noting "*work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,*" as no outcome/service received is included with the invoices.

We have confirmed that the approval of requisitions we viewed were made in accordance with the Scheme of Reservation and Delegation and within delegated limits.

The MHL Division has been raising individual orders to facilitate payment of invoices despite this being a long-standing Agreement, and one where an annual blanket order should have been raised, that would have necessitated additional approval and scrutiny.

We estimate the Health Board has paid £3,187,508 to Bangor University for the period April 2013 to September 2025, excluding the Charitable Fund contribution.

Health Board direct funding supporting the CfMHaS - £947,440 (estimate)

In reviewing the CfMHaS website, at the time of our review we found eight Health Board staff referenced as working/associated with it. In a meeting with the MHL Medical Director we confirmed the Health Board directly employs and supports the CfMHaS with 1.40 whole time equivalent (wte) staff and sought historical data from the Finance Directorate for 2012/13 to 2025/26 to confirm the direct funding. The total budget funding allocated for the period is £853,419 (£821,105 staff and £32,314 non-staff, excluding 2013/14 as data was not available). No recharges are made by the Health Board to Bangor University to recoup any of these support costs.

The CfMHaS use office accommodation within the Wrexham Medical Institute that the Health Board does not recharge any costs for its use. We contacted the Office of the Director of Environment and Estates to identify the costs for its utilities (water, gas and electricity); the actual costs

cannot be identified as the offices are not separately metered with the estimated costs being a pro-rata according to the floor space occupied. We did not seek the costs for any cleaning, maintenance or council tax elements and have been advised that the estimated utility cost is £94,021 inclusive of VAT for the period 2012/13 to 2024/25.

Honorary Contracts

In reviewing the Profile page¹ we noted several Honorary posts awarded by the Health Board and Bangor University respectively.

We contacted the Health Board's People & OD Directorate (POD) to establish the controls in place for awarding honorary contracts. We have been advised there is no register, currently, of officers issued honorary contracts by the Health Board and no central record of officers receiving honorary awards from Higher Education Institutions (HEI) also.

The Health Board Procedure *Health Research SOP B03 Standard Operating Procedure (SOP) for NHS Research Passports, Letters of Access and Honorary Research Contracts* does not require any POD involvement in awarding the honorary contract. Procedure *WP1C Consultants Recruitment Procedure – Appendix 3* specifies the process to be followed in awarding honorary contracts, including *"It is important that an NHS Organisation proposing to grant an honorary contract satisfies itself as to the practitioner's competence to carry out the clinical duties required; the NHS Organisation employer carries the same liability in law for the actions of its honorary staff as it does for its paid staff. An honorary appointee must also be on the Specialist Register."* Further we note that honorary contracts are exempt from advertising and selected by an Advisory Appointments Committee where no remuneration is made.

We sought evidence as to whether any record was held in the appointment of an honorary consultant psychiatrist; no record was held but we did receive a copy of two honorary contracts issued in 2017, with one being limited to six-months duration. Recognising the Agreement between the Health Board and Bangor University notes the three days clinical work per a work plan, it is unclear whether *The National Health Service (Appointment of Consultants) (Wales) Regulations 1996* has been complied with.

We sought evidence as to whether job plans existed for the two Honorary Consultant Psychiatrists to verify direct clinical care (DCC) and Supporting Professional Activity (SPA) sessions; the Office of the Medical Director Job Planning Team advised that no job plans were held for both honorary appointments.

Declarations of Interest (DOI)

We requested whether DOIs were up to date for the eight Health Board staff recorded on the CfMHaS web site. The Office of the Director of Corporate Governance provided us with details, and we found four had not made a DOI. The remaining four had made declarations, however only two directly related to BU, both made in 2024, with no current year declarations evident.

Benefits realisation from the Agreement

The Agreement has no pre-determined metrics or outcomes included on which to measure whether the benefit to the Health Board has been realised/continues to be realised – this is a significant omission from the Agreement and is not reflective of expected governance controls.

The MHL D Medical Director advised that having a clear research and development offer encouraged clinicians to apply and come to the Health Board; we are unable to corroborate this assertion. We have reviewed the Month 6 (September 2025) 2025/26 Finance report and found a vacancy total of 17.90 whole time equivalent (wte) Medical staff across the Centre (6.28wte), East (2.28wte), and West (9.34wte) respectively.

¹ <https://cfmhas.org.uk/profiles/>

Key Findings		Risk & Impact	Agreed Management Action
			Management statement: The management actions reflect a need to rapidly review the areas of compliance highlighted in the report and also to rapidly review the agreement for CfMHaS. The agreed actions identify a single action owner, and it has been agreed to develop a Health Board Task and Finish Group to enable whole Health Board support to progress the actions at pace.
1	Health Board Costs and resultant benefits The estimated costs to the Health Board through the Agreement with Bangor University is £4,292,733, including all invoice recharges from the University, direct funded costs incurred by the Health Board and the Health Board Charity's initial funding. No recharges are made by the Health Board for any support/premises costs, and it does not receive any income generated from grant/projects as this is all retained by the University, per the signed Agreement.	The Health Board cannot demonstrate compliance with Standing Financial Instruction 10.3.1 (e) in the procurement of services via the Agreement with Bangor University.	Agreed Action: Commission a full commercial and governance review of the 2012 Agreement, led jointly by Finance, NWSSP Procurement and MHL D, to: • Map <i>all</i> costs, recharges, income flows, and staffing associated with the CfMHaS. • Identify all areas of non-compliance with SFIs and Standing Orders. • Confirm whether current service delivery matches the contract specification. Introduce enhanced control for all invoices received from Bangor University, requiring: • Named senior officer sign-off confirming evidence of services delivered. • Documented confirmation that no duplicate funding exists. Deliverables • Full commercial review report with options appraisal including compliance with SFI 10.3.1(e). • Revised contract-management arrangements. Expected Evidence of Implementation: Immediate review of the Agreement and whether it continues to meet the needs of the Health Board, noting it is a service agreement which falls under the requirements set out in the Standing Financial Instructions and should be progressed with NWSSP Procurement Services input.
		High Priority	
Theme: Finance Management & Control		Control Operation	Officer: Executive Director of Finance (linking with NWSSP and MHL D) Date: 30 April 2026 for immediate compliance actions; 31 July 2026 for full contract review
2	Honorary Contracts Health Research SOP B03 <i>Standard Operating Procedure (SOP) for NHS Research Passports, Letters of Access and Honorary</i>	There is a risk that the Health Board could award an	Agreed Action: Establish a centralised Health Board register of all honorary posts, owned by People & OD, with mandatory entry before any work can commence.

	<i>Research Contracts</i> does not appear to include any People & OD involvement in awarding honorary contracts, to ensure compliance with Statute, particularly where Consultant staff are awarded contracts. There is no central register held by the Health Board where honorary contracts have been awarded, to ensure due diligence prior to issue. Two honorary contracts were issued in 2017 with one limited to six months duration (1 March 2017 to 31 August 2017) and one not end-dated. We have not been able to evidence whether the six-month contract was subsequently extended as we found the University invoiced for the individual in the invoice dated 28 March 2025. No job plans were evident to support two Honorary Consultant Psychiatrist appointments.	honorary contract without undertaking pre-employment checks as to the individual's eligibility to practice.	Introduce a mandatory assurance checklist for honorary appointments: • Confirmation of compliance with NHS (Appointment of Consultants) (Wales) Regulations. • Confirmation of agreed and signed job plans. Retrospective validation exercise for all current honorary appointments linked to CfMHaS, and all posts that have been subject to honorary contract award via the R&D Department and then extract learning to review the same in other services/operations of the Health Board. Deliverables • Central register live and maintained. • Fully validated list of all current honorary appointments for CFMS. • Job plan agreement for all consultant-level honorary roles. Expected Evidence of Implementation: The process for awarding honorary contracts across the Health Board is reviewed by the People & OD Directorate and a central register is held, ensuring all necessary pre-employment checks are completed. Consultant Job Plans are agreed and signed off where Honorary Consultant appointments are made.
	Theme: Governance	High Priority Control Operation	Officer: Executive Director of Workforce and OD Date: 30 April 2026
3	Declarations of Interest (DOI) We found limited DOI made by all officers employed by the Health Board but noted as fulfilling a role in the CfMHaS. Whilst these may be contractual and part of agreed work patterns, officers where Honorary research appointments or other awards have been made could be exposed to unintentional conflicts of interest.	Standards of Business Conduct is not embedded across the Health Board with staff fulfilling a dual academic/health care role exposed to risk of a conflict of interest.	Agreed Action: Carry out a targeted DOIs compliance sweep for all staff linked to CfMHaS, led by the Medical Director and supported by Corporate Governance. Establish if there is further information arising from this work to inform general BCUHB compliance. Deliverables 100% DOI compliance for CfMHaS-related staff. Expected Evidence of Implementation: Declarations of interest are maintained by employees to comply with the Standards of Business Conduct. Line managers ensure staff awarded honorary research/academic roles complete Declarations of Interest annually whilst holding such roles.
		High Priority	

	Theme: Governance	Control Operation	Officer: Executive Director of AHPs and Health Science (supported by Corporate Governance) Date: 31 March 2026

Objective 2: To consider the current and future arrangements in place between BCUHB and Bangor University in relation to the CfMHaS. (this should include a review of the clarity in terms of the services provided, the roles and responsibilities, the performance management arrangements and adherence to quality standards).

Advisory

Overview / Summary of Observations

Our finding is based on documentation shared with us and publicly available information at the time of the review.

The CfMHaS has its own website² with the Health Board logo included in the footer on its pages. The CfMHaS is listed as a dedicated Centre on Bangor University's *Research Institutes and Centres* website³ that notes: "Research Institutes and Centres are a central part of Bangor University."

Current arrangements

The current arrangement between Bangor University (BU) and the Health Board is underpinned by an Agreement (the Agreement) dated 5 July 2012 and signed by a University Accountant and former Associate Chief of Staff for the MHL D Clinical Programme Group (at the time of this review it is now the MHL D Division), commencing on 1 July 2012 for an initial period of sixty (60) months and remaining ongoing after this initial period, with opportunity for a break clause noted. This Agreement pre-dates the current MHL D management team.

We have confirmed that no formal review of the Agreement has been undertaken since it came into being on 1 July 2012.

We note the following key areas from the signed Agreement:

Background

- BU agreed to provide the Services and employees per the terms and conditions.
- BU may as part of the Services "...apply for additional grant/project funding over and above the services to BCUHB...The additional funding shall remain separate from this Agreement, unless agreed otherwise."

Obligations of the Parties (3)

"Provide such reports and other information...as may be required by BCUHB to ensure the efficient performance of the Services." (Para. 3.1.8).

Intellectual Property (4)

- "Subject to any third party contracts, BU shall own any and all Intellectual Property which is created during the course of the Services and BU shall be free to exploit...as it sees fit." (Para. 4.2).
- "Any Income generated by BU that results from the work (including but not limited to the clinical research work) of this Agreement shall be retained by BU. The BCUHB shall not be entitled to any additional pay or reward due to such income." (Para. 4.3).

General (12)

- "Nothing in this Agreement shall constitute a partnership between the Parties..." (Para.12.2).

² [Centre for Mental Health and Society](#)

³ [Research Institutes and Centres | Bangor University](#)

Schedule 1 – Services: Clinical Professor and Research Officer

- *"As a clinical academic employed by Bangor University the Clinical Professor (CP) will work 2 days a week on research...For 3 days a week the CP will work as an Honorary Consultant Psychiatrist...will follow a work plan agreed annually for (BCUHB)...".*
- *"The Research Officer's role will be to support a programme of research and research development, as directed by the CP."*

Our review of recent invoices submitted by BU has identified the recharge of four individuals (January to March 2025), yet the Agreement only allows for two posts. We are unable to verify who approved this increase as it is not reflective of the Agreement, and what benefit the Health Board is realising from this additional cost.

We sought evidence on oversight and scrutiny of the Agreement; the MHL D Medical Director advised there is a weekly CfMHaS management meeting that discusses project grants, but it is not a forum for oversight of the Agreement. The Medical Director also advised of the Academic Partnership Board (APB) that is accountable to the Together for Mental Health Partnership Board (T4MHPB), bringing together several partners to progress research and bridge the gap between clinicians and academics. The review of its Terms of Reference found no responsibility for oversight of the Agreement.

We note the APB records authority *"...to approve Memorandums of Understanding with each University Department, School and Research Centre..."* however the review of the Health Board's current Scheme of Reservation and Delegation does not allow for this.

We have been unable to identify any performance management or quality metrics set to gauge whether the service provided by BU to the Health Board is reflective of the Agreement or find any risks associated with MHL D research and development. This does not comply with Standing Financial Instruction 11.12.2 that notes *"Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities."* We also note that Standing Financial Instruction 11.16.1 *Contract Management* has also not been complied with as there is no evidence that performance meetings are held.

Future arrangements

Please refer to Objective 4 - We have reviewed the content of the SBAR prepared by the MHL D Medical Director that seeks to change the current Agreement and proposes three options.

Other issue noted

The Agreement records that BU may apply for grant income/project funding that remains separate to the Agreement and is over and above the services to the Health Board. We are unable to confirm that the services invoiced and paid for by the Health Board, more recently for four individuals, are also not included in any successful grant/project funding bids.

Key Findings		Risk & Impact	Agreed Management Action
4	Agreement There has been no review of the Agreement since it came into force on 1 July 2012 with an initial period of sixty months, with opportunities to break the Agreement noted. There are no documented performance measures or quality metrics built into the Agreement, and we found no evidence of	The Health Board cannot evidence the service provided by the University is as expected as no performance or quality metrics have	Agreed Action: Develop a CfMHaS Performance Framework with: • Agreed KPIs (outputs, research impact, grants, activity levels). • Six monthly monitoring reports to the Executive Committee (or another group if recommended) Deliverables Performance dashboard for CfMHaS.

	expected management oversight scrutiny of the Agreement in line with Standing Financial Instruction 11.12.2. There has been significant cost creep relating to the number of posts recharged to the Health Board. The Agreement only allows for two posts for service recharge, although recent invoices from the University note a recharge of four posts, it is unclear why these have been approved for payment. It is unclear whether the Health Board is reimbursing for individuals time that may also be included in successful grant/project income, which is managed directly by the University as noted in the Agreement.	been built into the Agreement, resulting in a risk of breaching its Standing Financial Instructions.	Expected Evidence of Implementation: Immediate review of the Agreement and whether it continues to meet the needs of the Health Board, noting it is a service agreement which falls under the requirements set out in the Standing Financial Instructions and should be progressed with NWSSP Procurement Services input.
	Theme: Governance	High Priority Control Operation	Officer: Executive Director of AHPs and Health Science (with support from Performance Team) Date: First dashboard content agreed by 31 July 2026
5	Academic Partnership Board (APB) The APB is a Health Board led meeting with several external partners to take forward elements of research and learning for the MHL D Division, which we recognise as good practice. There are elements of the Terms of Reference that do not appear consistent with expected Health Board assurance and governance arrangements e.g. reporting to the T4MHPB and not to a Health Board Committee; and approving Memorandum of Understanding, where the Health Board Scheme of Reservation and Delegation does not permit this.	There is a risk that the Health Board enters into Memorandums of Understanding by officers who are not delegated to do so, resulting in a risk of financial loss.	Agreed Action: Re-set governance routes: • Clarify APB remit, membership, delegated authority limits. • Align APB reporting lines to the appropriate Committee. • Remove any authority to approve agreements where not permitted by the Scheme of Delegation. Deliverables Revised APB Terms of Reference.
	Theme: Governance	High Priority Control Operation	Expected Evidence of Implementation: Full review of the role and remit of the Academic Partnership Board. Officer: Executive Director of AHPs and Health Science – (With support from Corporate Governance) Date: 30 April 2026

Objective 3: Assess and determine the value for money of these arrangements including the benefits of arrangements for the Health Board and the wider population. (in accordance with the documentation in place between the two parties).

Advisory

Overview / Summary of Observations

Managing Welsh Public Money records value for money as *"looking after taxpayers' resources properly, and using them carefully to deliver high quality, efficient services."*⁴ and can be further broken down into *Economy, Efficiency and Effectiveness (3Es)*.

In reviewing the costs recharged to the Health Board from the University and the direct staffing/non-staff costs budgeted for within the MHL Division, we considered whether the 3Es had been met.

- Economy – considers the actual cost of activities; how was this decided on; have the funds been used for the stated activities and, what additional funds have been added?

We have been unable to confirm the achievement of economy as there is insufficient backing information received by the Health Board detailing the purpose of the recharge. Costs have also increased recently where four staff are recharged for against the two staff set in the Agreement.

- Efficiency - considers whether activities were delivered in line with expectations including, were the funded activities delivered in line with the plan; what additional activities were delivered; was the cost of delivery as expected and, how has efficiency been measured and monitored?

We have been unable to confirm the achievement of efficiency as there is no record of the projects/services the funding is being used for in support of the invoices paid.

- Effectiveness - focuses attention on outcomes such as, have the funded activities achieved the expected results or outcomes; what additional outcomes have been achieved, if any; and how has effectiveness been maximised?

We have been unable to confirm that the funding paid has achieved what it set out to do as there are no outcomes specified and the funding is not specific.

As no metrics, expected outputs or service indicators are available, we reviewed the current and completed projects recorded by the CfMHaS.

The CfMHaS web site records current and completed projects, including how they were funded. Sixty-two (62) projects are recorded, and we found that the Health Board funded eight (8) projects. As no backing information is provided with the invoices, we are unable to discount the possibility that the Health Board has not paid twice for these projects i.e. in both the MHL recharge and from the separate Research & Development (R&D) funding stream.

There are several projects funded from outside the Health Board area and it is unclear whether the time and support funded by the Health Board have contributed to these, for which there is no evident benefit to the population of North Wales.

Key Findings

Risk & Impact

Agreed Management Action

⁴ [WG24091 Managing Welsh Public Money](#) – Paragraph 1.1.3 - Page 1

6	Achieving Value for Money through the Agreement Due to the lack of expected performance measures and clear stated outcomes in the Agreement, the Health Board is unable to evidence it has achieved value for money through this Agreement. There are several projects that report outside the Health Board area and management are unable to provide evidence how this research has made a positive impact for the population of North Wales.	There is a risk that the Health Board has spent limited revenue funds for which the delivery of value for money cannot be evidenced.	Agreed Action: See Key Finding 4
			Expected Evidence of Implementation: Immediate review of the Agreement and whether it continues to meet the needs of the Health Board, noting it is a service agreement which falls under the requirements set out in the Standing Financial Instructions and should be progressed with NWSSP Procurement Services input.
	Theme: Performance Monitoring	High Priority Control Operation	Officer: Executive Director of AHPs and Health Science Date: 31 July 2026

Objective 4: Assess and evaluate the proposal for future arrangements with the CfMHaS that are referenced in the “SBAR” that the Medical Director of Mental Health and Learning Disabilities has developed and make any suggestions thereafter.

Advisory

Overview / Summary of Observations

We reviewed the SBAR referenced *SBAR Bangor-BCUHB agreement 22.04.24* addressed to the Chief Executive Officer and former Executive Medical Director; in reviewing the document we have not corroborated the assertions made under subheadings of *Major activities; Strategy Implications; Current benefits linked to the Academic Department; and Risk Analysis*.

Through the SBAR, it is evident that the Mental Health and Learning Disabilities (MHLD) Medical Director is seeking to amend the current agreement as “...the MHLD division and BCUHB are not benefitting from the revenue produced via research grants, in particular for the staff time dedicated to the projects. It is proposed to modify the agreement to enable BCUHB to recharge for the aforementioned time once research grants are obtained and to create a formal joint appointment between the two institutions”. We have confirmed with the Finance Directorate that no recharges are made to Bangor University for any Health Board staff time that support the administration/research undertaken within the CfMHaS.

The SBAR details three options, with option 3 the preferred solution:

1. *Continue with the historical agreement and annual renew. This option will not interest potential candidates as it is not attractive to have one year contract at time.*
2. *Support the proposed agreement to continue with the posts until further notice. This option will stabilise the posts, but BCUHB will not have the added financial benefits of recharging for the time dedicated to research. Furthermore, the research portfolio will remain at Bangor University.*
3. *Formalise the clinical professor and clinical senior lecturer posts as a joint appointment and retaining the research posts within BCUHB, with the specification of recharging from grants for the time dedicated (preferred). This will allow to recharge the costs of clinical time from grants and will increase BCUHB research portfolio. It will also allow to ring-fence the posts and maintaining the prestige.*

The Department for Education and Skills review ‘A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties’, referenced as the Follett Inquiry, set out key principles that academic and NHS organisations should adhere to. Health and Care Research Wales signpost to ‘New guidelines to support health and care professionals: The Follett Principles’.⁵ The Principles focus on a joint approach to the recruitment, appointment, induction, job planning, appraisal with a clear process for the management of performance and conduct, between the NHS and Higher Education Institutions, something that the current agreement does not comply with; Option 3 would appear to address this.

On 31 July 2023, Welsh Health Circular (WHC) *NHS framework for research and development* (WHC/2023/026)⁶ was issued and signposted to ‘Research matters: What excellence looks like in NHS Wales’ published by Health and Care Research Wales. The review of the document has identified the current and proposed arrangement between the Health Board and Bangor University (via the CfMHaS) may not address elements of the WHC and note challenges relating to Section 5 – Research Delivery and Section 6 – Finance.

The Health Board’s Integrated Medium Term Plan (IMTP) for 2025-28 sets out the priorities by Strategic Objective; Objective 5 *Effective*

⁵ [New guidelines to support health and care professionals: The Follett Principles | Health Care Research Wales](#)

⁶ [NHS framework for research and development \(WHC/2023/026\) | GOV.WALES](#)

environment for learning and skills development is underpinned by Priority 5B: Research, Development and Innovation with 5B.3 stating the intention for 2025/26 to "Increase the number of joint appointments and honorary research appointments with our academic partners" and Option 3 appears to support this.

The SBAR focuses solely on continuing the arrangement with Bangor University and the CfMHaS; it does not consider other academic partners e.g. Wrexham Glyndwr University.

We reviewed the Job Plans for the three Health Board Consultant Psychiatrists with a noted role with the CfMHaS. We found two of three job plans had not been agreed at the time of our review, with one and four Supporting Professional Activity (SPA) sessions, specifically recorded as research, not agreed. The one consultant with an agreed job plan has two research defined SPA sessions; we are unclear whether these two SPA sessions are used in support of the CfMHaS for which grant funding/income has also been received, where the Health Board receives no income. We note the focus and steps being taken to address consultant job planning in the Health Board and have not raised this as an issue.

We reviewed the MHL D Divisional risk register and could find no specific risk associated with Research and Development.

Key Findings		Risk & Impact	Agreed Management Action
7	Future arrangements The MHL D Medical Director has identified the Health Board is "...not benefitting from the revenue produced via research grants.". Whilst the preferred Option 3 within the SBAR does progress the recharging of costs, it appears to fall short of addressing all areas outlined in Welsh Health Circular <i>NHS framework for research and development</i>. The SBAR also seeks to progress the current arrangement with Bangor University and does not factor in other academic partners within North Wales e.g. Wrexham Glyndwr University. As such it cannot be demonstrated that the continuation of these arrangements, albeit with a revised offer to recoup time costs from grant income, offers the optimum solution for the Health Board. There is no specific risk associated with research and development within the MHL D risk register. The Division appears to be operating independently of the wider Health Board research and development agenda, and it is unclear how this will support the delivery of IMTP agreed actions.	There is no defined risk associated with research and development and there is a risk that the Division is not allocating limited revenue funding to areas of higher risk.	Agreed Action: Undertake a whole system review of research and development in the Health Board (including MHL D) to ensure compliance with WHC/2023/026. Commission a formal R&D System Review covering: • Compliance with Welsh Government WHC/2023/026, • wider academic partnerships (not only Bangor), • research governance, • integration into Health Board R&D strategy, • impact measurement. Deliverables • System review report with recommendations. • R&D risk added to Divisional and corporate risk registers. • Integration plan into corporate R&D Programme Board. Expected Evidence of Implementation: Whole system review of research and development within Mental Health and Learning Disabilities to ensure compliance with WHC/2023/026 NHS framework for research and development. Ensure that the MHL D Division integrates seamlessly with the broader Health Board Research and Development programme to fulfil the IMTP required actions, rather than functioning independently.
Theme: Strategy		High Priority Control Operation	Officer: Executive Medical Director (With support from the Medical Director for Mental Health)

			Date: 31 July 2026

Objective 5: Make recommendations on the legal requirements for the constitutional arrangements for the Centre for Mental Health and Society, assess how these are currently being met and any subsequent recommendations for improvement.

Advisory

Overview / Summary of Observations

We are unable to comment on the constitutional arrangements of the Centre for Mental Health and Society as it appears to be a Bangor University centre based within the College of Human Sciences, as noted on the University website⁷. We have been advised recently that the College of Human Sciences has been renamed as the 'College of Medicine and Health'.

The Health Board's involvement is limited, per the Agreement, to the payment for Services it receives from Bangor University with the staff appointed by the University under the current Agreement.

We have made no recommendation on the constitutional arrangements for the CfMHaS; however, the Health Board should ensure that NWSSP Procurement Services are involved in the review of the agreement going forward.

⁷ [Research Institutes and Centres | Bangor University](#)

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.

Disclaimer

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

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the 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.

Public Sector Internal Audit Standards

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

