

Bundle BCU Audit, Risk and Assurance Committee 20 October 2026

- 0 AC26.110 Supporting papers - Internal Audit reports
- 1 Internal Audit final report : Delivery of Savings
BCU-2627-12 Final IA report Delivery of Savings
- 2 Internal Audit final report : Foundations for the Future Project delivery
Revised and updated 29.10.26
BCU-2627-04 Final Internal Audit report Foundations ft Future Project Deliveryv1
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Delivery of Savings

Final Internal Audit Report

2026/27

Betsi Cadwaladr University Health Board



Reasonable Assurance

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Review Reference

Fieldwork
Executive Sign Off
Audit Committee
Executive Lead
Audit Team

BCU-2526-12

July - August 2026

8 October 2026

October 2026

Russell Caldicott, Executive Director of Finance

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

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Audit and Assurance Services



Executive Summary

Purpose

To review the effectiveness of governance, management, and reporting arrangements in the identification and delivery of savings as outlined in the IMTP - Financial Plan for 2026/27.

Overview

The Health Board has established effective governance, management, and reporting arrangements to support the identification, development and monitoring of savings schemes, with evidence that schemes are being progressed towards the Health Board's £46m savings target. However, formal recovery planning arrangements and processes for monitoring and tracking recovery actions for forecast savings shortfalls are still developing.

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

- One sampled savings scheme lacked sufficient supporting detail within the approved SSD to support effective scrutiny and challenge of the projected savings.
- The basis for classifying one £34k scheme as cost avoidance was subject to challenge due to its link to costs arising from service underperformance.
- Testing of reported savings identified limited supporting evidence for two sampled schemes and a minor overstatement of savings delivery in one scheme due to planned savings being reported instead of actual savings achieved.
- Formal recovery planning arrangements for addressing forecast savings shortfalls, including contingency measures and documented recovery plans, were still under development at the time of review.
- Formal processes for monitoring, tracking and evaluating recovery actions for underperforming savings schemes require further development, limiting assurance that emerging delivery issues are being addressed consistently and effectively.

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

Scope & Assurance Summary

Objectives <small>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.</small>		Related Findings	Assurance
1	Effective governance and robust processes are in place to identify, develop, and approve savings schemes that are realistic, deliverable, and aligned to the £46.0 million target.	1, 2	Reasonable
2	Robust management arrangements and controls are in place to support the implementation and delivery of savings schemes, including clear accountability, tracking of progress, and timely intervention where delivery is at risk.	3, 4	Reasonable
3	Effective reporting, escalation, and risk management arrangements are in place to provide timely and reliable insight into savings delivery, identify variances and underperformance at an early stage, and enable appropriate corrective action to mitigate the risk of non-delivery.	5	Reasonable

Management Actions



High-Priority



Medium Priority

Themes



■ Finance
Management &
Control

Risk Types

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Effective governance and robust processes are in place to identify, develop, and approve savings schemes that are realistic, deliverable, and aligned to the £46.0 million target.

Reasonable

We confirmed that the Health Board has established governance arrangements to support the identification, approval and oversight of savings programmes. Savings performance is routinely reported through a defined governance structure comprising the Value and Sustainability Programme Board, the Integrated Performance and Executive Delivery Group (IPEDG), the Performance, Finance and Information Governance Committee (PFIG), and the Health Board. Approved Terms of Reference are in place to support accountability and oversight.

Clear reporting arrangements have been established to monitor savings targets, forecast delivery, recurrent and non-recurrent savings, and Value and Sustainability (V&S) initiatives. Roles and responsibilities are formally documented through Budget Manager Accountability Agreements, financial procedures, and programme governance structures, with defined responsibilities for operational leads, finance leads, and executive oversight. While Finance performs a review, validation and challenge function, responsibility for identifying and delivering savings opportunities remains with individual service areas. Evidence was provided demonstrating challenge by both Finance and service managers during the development and review of savings proposals.

Proposed savings schemes are subject to the Health Board's structured savings approval process, supported by documented guidance. All scheme proposals are required to be fully documented, allocated to a Senior Responsible Officer, and submitted using a standardised Savings Submission Document (SSD). Each SSD is subject to review, verification and approval before being incorporated into the Health Board's savings plan. Once approved, schemes are assigned a green RAG rating and recorded on a centrally managed tracker, which is updated monthly to support ongoing monitoring and reporting.

As of June 2026 (Month 3), the Health Board had identified and approved 95 savings schemes, providing a total forecast delivery of £24.4m against the £46m savings target. By the end of July 2026 (Month 4), approved schemes had increased to £43.9m, with a further £11.6m identified as pipeline schemes, indicating that the Health Board has made significant progress in identifying sufficient opportunities to meet its savings target, subject to successful delivery.

While governance arrangements and scheme approval processes are established and clearly defined, our testing did not extend to a detailed assessment of the robustness of savings assumptions, the consistency and effectiveness of challenge applied during scheme development, or the assessment of implementation risks prior to scheme approval. However, for the schemes sampled, savings delivered at Month 3 (£1,126,618) exceeded the planned level of delivery (£1,097,664), providing evidence that approved schemes were delivering in line with expectations at the time of review.

Key Findings		Risk & Impact	Agreed Management Action
1	Saving Submission Documents (SSD) We reviewed the approved Savings Submission Documents (SSD) for a sample of ten saving schemes and noted the following limitation:	There is a risk that: Savings assumptions may not be subject to effective scrutiny	Agreed Action: The Health Board will reinforce and strengthen the existing SSD guidance and review process. Guidance will be updated as necessary and will require each SSD to include, or clearly cross-reference, sufficient supporting financial analysis to demonstrate how the forecast saving has been calculated, including the key

	<p><u>Mental Health and Learning Disabilities – Scheme MHL26002 Right Care Programme</u></p> <p>We were unable to determine from the supporting financial analysis how the projected savings had been calculated and therefore could not assess whether the underlying assumptions and costings were sufficiently robust.</p> <p>Although additional information was provided on request, the approved documentation did not contain sufficient detail to demonstrate compliance with the Health Board's documented guidance or to support effective scrutiny and challenge prior to approval.</p>	<p>and challenge before approval.</p> <p>Approved schemes may not be supported by sufficient evidence to demonstrate compliance with guidance.</p>	<p>assumptions, baseline, phasing and recurrent/non-recurrent impact where applicable.</p> <p>The current assessment of the quality and robustness of the supporting financial analysis will be strengthened before an SSD is included on the tracker. Where information is incomplete, but only minor elements are outstanding, a pragmatic view will be taken, with any missing information requested retrospectively. This will enable valid savings to be reflected in the Monthly Return (MR) in the same month that the associated ledger and/or forecast adjustment is made.</p> <p>Expected Evidence of Implementation:</p> <p>All SSDs supported with robust financial analysis / backing documentation in compliance with BCU Guidance for Savings (2026-27).</p>
	<p>Theme: Finance Management & Control</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Head of Financial Reporting</p> <p>Target Implementation Date: 31/03/27</p>
<p>2</p>	<p>Legal Cost Avoidance Scheme</p> <p>We reviewed the classification of £34k reported cost avoidance relating to clearance of a backlog of radiology disclosure requests (DSCS26001-01). In our view, the backlog arose due to the service not meeting required disclosure timescales, and there is a risk that the resulting legal cost avoidance reflects the prevention of costs arising from operational underperformance rather than a genuine efficiency, service redesign, or reduction in planned expenditure. Management advised that no benefit has been claimed for restoring operational performance. Instead, the claimed benefit relates to the avoidance of legal costs associated with 17 cases where solicitors had indicated an intention to pursue pre-action disclosure orders. Documentary evidence was provided to support the estimated financial exposure and management's assessment that the scheme meets the definition of cost avoidance.</p>	<p>There is a risk that costs arising from operational underperformance may be incorrectly reported as savings, with reported savings not representing genuine, sustainable financial benefits.</p>	<p>Agreed Action:</p> <p>Management notes the auditor's challenge regarding the classification of this scheme. The benefit claimed related specifically to evidenced legal costs that were expected to arise from identified cases, rather than a benefit attributed simply to restoration of operational performance.</p> <p>To ensure consistency of interpretation, the Health Board will seek clarification, where necessary, from Welsh Government on the application of the national cost-avoidance definition to circumstances of this nature.</p> <p>The Health Board's savings guidance will continue to be reviewed where necessary, to ensure clear criteria and examples for the classification of cost avoidance and to ensure consistent treatment of schemes.</p> <p>Expected Evidence of Implementation:</p> <p>All proposed Health Board saving schemes are subject to robust review, challenge, and scrutiny prior to approval, ensuring compliance with relevant local and national guidance.</p> <p>Officer: Head of Financial Reporting</p>
		<p>Medium Priority</p>	

	Theme: Finance Management & Control	Control Operation	Target Implementation Date: 31/03/27
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Objective 2: Robust management arrangements and controls are in place to support the implementation and delivery of savings schemes, including clear accountability, tracking of progress, and timely intervention where delivery is at risk.

Reasonable

The review identified several positive management controls supporting the delivery and monitoring of savings schemes. The Health Board's savings target of £46m has been allocated across service budgets (2.4% across all budgets apart from ringfenced) and reflected through budget-setting processes, with arrangements in place to distinguish between recurring and non-recurring savings. A central savings tracker maintained by the Financial Reporting Team provides the primary mechanism for recording scheme status, ownership, actual and forecast delivery, and reporting information. Regular reporting takes place through a range of governance forums, including Health Board, PFIG and IPEDG, supported by more frequent reporting where required.

The arrangements establish clear accountability for delivery, with scheme owners identified and divisional CFOs responsible for monitoring performance at a local level. The tracker incorporates scheme-level monitoring information and is supported by service-level reporting and central corporate oversight. Collectively, these arrangements provide management with a consolidated view of savings performance and progress against the overall savings requirement.

To assess the robustness of these arrangements, we sought to verify reported savings delivery for our sample of ten schemes at Month 3 against supporting source documentation. Evidence confirming the reported savings delivered was provided for eight of the ten schemes reviewed; supporting information for the remaining two schemes was outstanding at the time of reporting.

Whilst the controls in place are largely operating as intended, arrangements for managing schemes that are at risk of non-delivery are less mature. Management acknowledged that, to date, the Health Board's focus has primarily been directed towards identifying and approving sufficient schemes to underpin the savings target. Formal recovery planning processes, including documented corrective actions, ownership of recovery plans, delivery milestones and monitoring arrangements, are still being developed. Similarly, while management reporting identifies forecast shortfalls, limited evidence was provided to demonstrate systematic intervention, escalation and monitoring of recovery actions at scheme level. Further work is therefore required to strengthen arrangements for managing under-performance and providing assurance that emerging delivery risks are addressed promptly and consistently.

Key Findings		Risk & Impact	Agreed Management Action
3	<p>Actual Savings Reconciliation</p> <p>At Month 3 our sample (10) schemes had reportedly delivered £1,126,618 of savings. We requested evidence of delivery and sought to reconcile working documents to the savings tracker. We noted the following limitations:</p> <ul style="list-style-type: none"> Evidence / backing documentation was not provided for two (2/10) schemes in our sample: <ul style="list-style-type: none"> Central: Decision Support Software (MM26060-02), and 	<p>There is a risk that:</p> <p>Reported savings may not be supported by sufficient evidence to demonstrate actual delivery.</p> <p>Savings delivery may be misstated</p>	<p>Agreed Action:</p> <p>Immediate action: Finance will reinforce the requirement that reported savings delivery must be supported by appropriate auditable evidence and reflect actual delivery rather than planned or expected delivery.</p> <p>In addition, the guidance will be strengthened to make clear that spot checks of supporting evidence may be undertaken at any time and that a sample review of reported savings will be conducted twice annually.</p>

	<ul style="list-style-type: none"> ○ Corporate: Postal Hub Maintenance Contract (FACE26002-02) • Primary Care: Workforce, Purchased Annual Leave Savings (WFVS26001-41) - Planned savings had been reported instead of actual savings achieved, resulting in a marginal overstatement of savings delivery of £1,111 over the three-month period. The Head of Financial Reporting advised that IHCs will be reminded to use ledger information when reporting savings delivery going forward. 	where planned savings are reported instead of actual savings achieved.	
	Theme: Finance Management & Control	Medium Priority	Expected Evidence of Implementation: All reported savings supported with robust backing documentation demonstrating actual delivery.
4	Recovery Planning Formal recovery planning arrangements for forecast savings shortfalls are still developing. Management advised that the initial focus during 2026/27 has been on identifying and approving sufficient schemes to support the savings requirement. Formal recovery planning arrangements, including documented recovery plans, contingency measures, defined ownership and milestones for addressing forecast savings gaps, are still being developed. Consequently, there is limited evidence that a consistent and proactive approach is in place to address significant shortfalls in savings delivery.	Control Operation	Officer: Head of Financial Reporting Target Implementation Date: 31/03/27
			Agreed Action: The recently approved Integrated Performance and Accountability Framework establishes the Health Board's arrangements for performance monitoring, accountability, recovery planning and escalation where performance domains are off plan. Under the Framework, areas of underperformance are required to develop and monitor recovery plans, with progress reviewed through established performance management arrangements and, where necessary, subject to escalation and increased oversight. The implementation of the framework is in its early stages but going forward, forecast savings shortfalls will be managed through these arrangements, ensuring that recovery actions, accountable leads, milestones and mitigating actions form part of the Health Board's performance and accountability processes.
			Expected Evidence of Implementation: A documented recovery planning framework outlining contingency arrangements, ownership, escalation requirements, timescales, reporting arrangements, and actions required where forecast savings shortfalls are identified. Recovery plans for forecast savings gaps showing mitigating actions, accountable officers, target dates, expected financial impact, and progress updates.
	Theme: Finance Management & Control	Medium Priority	Officer: Head of Financial Reporting Target Implementation Date: 31/03/27
		Control Design	

Objective 3: Effective reporting, escalation, and risk management arrangements are in place to provide timely and reliable insight into savings delivery, identify variances and underperformance at an early stage, and enable appropriate corrective action to mitigate the risk of non-delivery.

Reasonable

We found that reporting and escalation arrangements for savings delivery are generally well defined. Savings performance is monitored through a structured governance framework involving Chief Finance Officers, Integrated Health Communities, executive accountability meetings, the Programme Board, IPEDG and PFIG. Reporting is based on forecast outturn positions rather than planned delivery profiles, enabling deteriorating performance and forecast shortfalls to be identified at an earlier stage.

We reviewed the savings performance reported in the Health Board Finance Reports (Months 2 and 4 presented to PFIG, and Month 3 presented to the Health Board) and identified no significant issues. We were able to fully reconcile the reported position to source data within the savings tracker.

In addition, we were advised that fortnightly review meetings between Finance and Value and Sustainability leads and workstream representatives provide a mechanism for discussing delivery issues, risks and emerging concerns. However, we were unable to verify this through documentary evidence as minutes are not maintained. Evidence was provided that executive accountability processes, including Chief Executive Officer-led meetings, have been utilised where services had not fully identified savings plans against their allocated targets.

High-level savings risks are incorporated into programme governance through a formal Value and Sustainability risk register. Risks are assigned ownership, assessed for likelihood and impact, and supported by mitigating actions. The risk register is reviewed by the Programme Board and informs wider governance discussions on delivery risk and financial performance. In addition, savings-related risks are reflected in Health Board Finance Reports presented to both the Health Board and PFIG. These arrangements provide a clear mechanism for escalating and monitoring key delivery risks.

Whilst the reporting, governance and risk management framework provides management with timely information on performance and emerging delivery risks, we identified limitations in the maturity of arrangements for responding to delivery underperformance. Management confirmed that formal recovery planning processes remain under development and that focus has not yet fully transitioned to managing savings delivery shortfalls. Consequently, limited evidence was available to demonstrate that recovery actions are consistently documented, monitored and escalated through governance structures.

Key Findings		Risk & Impact	Agreed Management Action
5	<p>Recovery Actions</p> <p>Formal processes for monitoring and tracking recovery actions require further development.</p> <p>Although escalation routes are defined and risks are monitored through governance structures, limited evidence was available to demonstrate a consistent process for documenting, assigning, monitoring and evaluating corrective actions where individual savings schemes are at risk of under-delivery. As a result, there is reduced assurance that management</p>	<p>There is a risk that corrective actions for underperforming savings schemes may not be consistently documented, assigned or monitored, with management</p>	<p>Agreed Action:</p> <p>The Integrated Performance and Accountability Framework introduced in response to Finding 4 will incorporate a consistent mechanism for recording, assigning, monitoring and closing recovery actions for savings schemes forecasting material under-delivery.</p> <p>The existing savings tracker and/or supporting recovery documentation will record the action required, accountable owner, target date, expected financial impact and current status. Progress will be reviewed through the existing savings</p>

	interventions are implemented in a timely manner and are effective in addressing emerging delivery issues.	unable to demonstrate that interventions are timely, appropriate and effective in addressing delivery issues.	monitoring and governance arrangements, with overdue or ineffective actions escalated where appropriate. Recovery actions will be periodically reassessed to determine whether they remain sufficient to address the forecast shortfall and, where they do not, further mitigation or escalation will be required.
			<p>Expected Evidence of Implementation:</p> <p>A documented process for identifying, recording, assigning, escalating and monitoring corrective actions for individual savings schemes identified as off track.</p> <p>Action tracking records for underperforming schemes showing corrective actions, accountable officers, target dates, progress updates, and evidence that the effectiveness of interventions has been reviewed through appropriate governance arrangements.</p>
		High Priority	
Theme: Finance Management & Control		Control Design	<p>Officer: Head of Financial Reporting</p> <p>Target Implementation Date: 30/11/26</p>

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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

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

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.

Global 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, as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Foundations for the Future (FftF) – Project delivery Internal Audit Report 2026/27

Betsi Cadwaladr University Local Health Board



Limited Assurance

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Review Reference

BCU-2627-04

Fieldwork

June - August 2026

Executive Sign Off

7 September 2026

Audit Committee

October 2026

Executive Lead

Carol Shillabeer, Chief Executive

Audit Team

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the governance and delivery of the Foundations for the Future Programme.

Overview

Programme governance is not at a level expected for a programme of this significance. The draft Programme Initiation Document (PID) is unapproved and lacks key information on scope, cost, timescales, success criteria and measurable benefits. Also, the Programme Board is operating without an approved Terms of Reference, and programme plans have not been consistently maintained or monitored.

Programme delivery is impacted by resource constraints, with the programme reliant on existing staff undertaking programme responsibilities alongside operational duties. Evidence of delayed actions missed milestones, incomplete delivery plans and extension of target dates indicates that risks to delivery have materialised and is affecting programme progress.

Governance arrangements at workstream level require review. No terms of reference, meeting minutes or supporting papers were available to evidence that workstreams are operating effectively, with appropriate oversight, reporting and escalation to the Programme Board.

The proposed organisational structure carries significant financial and implementation risks, with capacity at the Executive a particular emerging risk as some Officers are scheduled to leave soon.

There is uncertainty over the reintroduction of roles previously removed from the structure, and current costing of the proposed structure forecast an increase in costs, as a result of possible new roles and current roles not fully funded in the General Ledger. The final model remains subject to consultation, limiting assurance over the accuracy, achievability and sustainability of projected costs.

There has been a heavy reliance on verbal updates to the People & Culture Committee; the absence of detailed written reporting limits the Committee’s ability to effectively scrutinise and challenge programme progress and fulfil its assurance responsibilities to the Board.

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

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1.	There is appropriate governance in place for the Programme and workstreams. We will consider whether key decisions made are in line with the governance structure / Scheme of Reservation and Delegation (where relevant).	1,2,3	Limited
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.	4,5	Limited
3.	There is reporting to the Health Board/Committee on performance of the Programme.	6	Limited

Management Actions



High Priority



Medium Priority

Themes



- Finance Management & Control
- Governance
- Planning, Delivery & Deadline Management
- Reporting
- Risk Management

Risk Types

Quality or Safety Issues

Financial Loss

Findings & Agreed Action Plan

Objective 1: There is appropriate governance in place for the Programme and workstreams. Key decisions made are in line with the governance structure / Scheme of Reservation and Delegation (where relevant).

Limited

Overview / Summary of Observations

A draft Programme Initiation Document (PID) for Foundations for the Future (FftF), dated 17 November 2024 (v0.6), has not yet been approved and contains significant gaps in key information. Critical success criteria relating to cost, time and scope are noted as 'TBC', while the documented benefits relating to Patient Experience, Staff, System, and Care & Quality lack sufficient detail and measurable outcomes to enable effective assessment of benefits realisation.

The PID identifies a key dependency that *"sufficient programme resources are available to support the programme"* and recognises resource constraints stating *"Programme Team members are current BCUHB employees. There will be no additional or external resource available, therefore the Programme Team will have to deliver this programme of work alongside their other daily duties. This may have a negative impact on delivery timeframes."* The review of reporting to the June 2026 People and Culture Committee indicates that this risk has materialised, with actions slipping past their expected delivery timelines and completion timelines extended.

The Programme Board is operating without an approved Terms of Reference (ToR); and we have confirmed that the Executive Committee has not received the ToR for approval.

The Foundations for the Future Programme was established as a major change programme and was downgraded to a key programme from 1 April 2026. The Transformation and Improvement Project Workbook template (latest dated 8 September 2025) was used to record tasks, start and end dates with milestones. The programme plan has not been maintained, with a recorded start date of 13 February 2025 and latest end date of 31 March 2026.

Since January 2026 a High-Level Delivery Plan has been maintained, however gaps in milestone completion dates across workstreams undermines its purpose to track and monitor delivery.

A review of Programme Board papers and minutes from April, May and June 2026 identified the following:

- The draft Terms of Reference was included on the three agendas, however there is no evident approval for submission of the ToR to the Executive Committee.
- The Programme Board does not appear to have been quorate as there is no operational representative recorded as present in the minutes, despite this being a requirement set out in the draft ToR, section 8.1: *"At least one third of members must be present to ensure the quorum, including the Chair or their deputy, a Clinical Representative, an Operational Representative and a Workforce & Organisational Development representative"*.
- Programme plan changes to action end dates and gaps in the programme plan, and impact on overall delivery, are not evident as being reviewed by the Programme Board. The current High-Level Delivery Plan has some gaps in target dates, with proposed end dates passed without being updated.
- A sample of six identified actions from the High-Level delivery plan that could be matched to the 8 September 2025 Project Workbook was undertaken, which showed slippage compared to the current programme schedule, ranging between one and eighteen months from the original end dates.

- The Programme Directors report includes details of programme and workstream risks. In reviewing these we found differences in risk reported and those recorded on the Portal (system that captures the Programme risk). We also noted there was limited consideration and discussion of the risks and mitigations in place.

In the June 2026 Programme Board meeting, we noted a decision taken to extend interim Band 8b and below posts associated with the programme until March 2027. However, LHB Model Standing Orders Reservation and Delegation of Powers (note 14F) delegates this authority to service directors "...*(i) Agree acting up salaries for staff a) Staff up to Band 9, within budget* is delegated to the Service Director (Tier 4)".

Key Findings		Risk & Impact	Agreed Management Action
1	Programme oversight and delivery The High-Level Delivery Plan captures the expected actions and timelines for delivery. Some gaps in dates were noted and end dates were revised, however it is unclear whether these were approved by the Programme Board or that their impact on overall programme delivery had been assessed. For a small number of actions there were gaps in the action owner, and some actions showing as completed but with no actual completion date noted. We found updated end dates indicating July 2027, however these are not reflected in the Delivery Plan graphical chart, so the impact on any interdependency is unclear.	There is a risk that the Programme Board is unable to effectively oversee delivery of the overall programme due to insufficient scrutiny and challenge of changes to action end dates, and the impact on interdependent activities.	Agreed Action: <ul style="list-style-type: none">• Review the format of the monthly Programme Directors Report to clearly identify items requiring comment, support or agreement.• Introduce a more structured monthly review of the High-Level Delivery Plan through the Programme Board.• Ensure significant milestone changes, revised timelines, dependencies and associated risks are formally recorded and monitored through monthly Programme Board reporting.• Look at how we can make the relationship to the ADP reporting/delivery confidence clearer in the Programme Directors Report.
			Expected Evidence of Implementation: <ul style="list-style-type: none">• High-Level delivery plan subject to regular review at Programme Board.• Programme Board agenda includes routine review of the High-Level Delivery Plan.• Programme Directors Report revised to clearly identify the purpose of each item and whether it is presented for comment, support or agreement.• Significant milestone and timeline changes formally recorded and monitored.• Ownership and target dates evident for all key programme milestones.
		Theme: Planning, Delivery & Deadline Management	High Priority
2	Risk review		Agreed Action:

	<p>Whilst the risks to the programme and products are included in the Programme Directors Report (PDR), there was no evident minutes supporting regular review by the Programme Board to corroborate the identified controls were impacting positively to control the risk materialising.</p> <p>We noted differences in the reporting of some risks in the PDR compared to source evidence retained by the Programme in the Portal.</p> <p>Recent reporting to the People & Culture Committee on 11 June 2026 advised <i>"A key area of concern relates to the resourcing required to support the forthcoming consultation and implementation phases, where a high-level programme risk has been identified..."</i>. We found this was recorded as a key dependency in the draft Programme Initiation Document in 2024, thus suggesting the mitigating controls have not had the desired impact.</p>	<p>There is a risk that risks to the successful delivery of the Programme are not subject to sufficient scrutiny by the Programme Board, reducing its ability to effectively mitigate risks to the achievement of expected outcomes.</p>	<ul style="list-style-type: none"> Continue to include programme and workstream risk review as a standing agenda item at Workstream and Programme Board meetings. Record risk discussions, challenge, mitigating actions and escalation decisions within meeting records. Review risk reporting processes and investigate discrepancies between The Portal and programme reporting documentation to ensure consistency and accuracy <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> Minutes of meetings include review of programme and workstream risks. Risk review included as a standing agenda item at Workstream and Programme Board meetings. Meeting records demonstrate review, challenge and escalation of programme risks. Review completed of risk reporting between The Portal and programme reporting documentation. Actions identified and implemented where reporting inconsistencies are found.
	<p>Theme: Risk Management</p>	<p>High Priority</p> <p>Control Operation</p>	<p>Officer: Programme Director / Programme Manager</p> <p>Target Implementation Date: 31st October 2026</p>
<p>3</p>	<p>Delegation of Powers</p> <p>As no Terms of Reference exist for workstreams, we were unable to confirm that decisions were made in accordance with delegated responsibilities. Also, as the Programme Board's Terms of Reference have not been approved by the Executive Committee, there is no formally approved delegation of authority to the Programme Board.</p> <p>We found one instance in the June 2026 Programme Board meeting where a decision was taken to extend interim 8b and below posts associated with the programme until March 2027. Under the Health Board's Scheme of Reservation and Delegation, authority to approve this is delegated to the relevant Service Director (Tier 4).</p>	<p>There is a risk that decisions are taken without the appropriate authority, as Terms of Reference have not been formally approved and do not explicitly define the scope of delegated responsibilities and decision-making authority.</p>	<p>Agreed Action:</p> <ul style="list-style-type: none"> Progress the revised Programme Board Terms of Reference through the appropriate approval process. Develop and implement Terms of Reference for all Workstreams. Confirm membership requirements, including operational representation, and ensure governance arrangements remain aligned with organisational requirements. <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> Approved Terms of Reference detailing role and responsibility. Approved Programme Board Terms of Reference. Approved Workstream Terms of Reference. Membership, reporting arrangements and quorum requirements formally documented.

		High Priority	Officer: Programme Director / Programme Manager
	Theme: Governance	Control Operation	Target Implementation Date: 31 st December 2026

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.

Limited

Overview / Summary of Observations

Five workstreams were established by the Programme Board: Strategy; Culture; People; Structures; and Processes, with the Culture and People Workstreams merging with their first meeting on 2 July 2026.

Governance arrangements at workstream level are not sufficiently documented - there are no minutes, papers or terms of reference available for review, however action logs are maintained. We are unable to determine whether the workstreams are meeting as expected and the matters considered at meetings.

We reviewed the Workstream Product Descriptions, which should set out planned actions and delivery timescales. None of the documents were dated so we were unable to reconcile all the High-Level Timescales/Key Milestones to the High-Level Delivery Plan.

We noted that the Strategy workstream is recorded as being stood down on 29 April 2026, however it is unclear whether this decision had been formally approved by the Programme Board.

Financial impact of FftF – Structures Workstream

Following initial lockdown of the new organogram (v1.6) on 26 May 2026 at the Structures Workstream, Finance received a subsequent update (v3.1) on 12 June 2026, with further proposed changes advised on 10 August 2026, reflecting amendments and additions proposed by Directors. Costings have been calculated using the top point of the pay band, in line with Health Board policy.

Comparing the current funded establishment and the posts identified within the new FftF model, the following observations were made. As the final structure has not yet been agreed or consulted upon, all costs and savings are indicative:

- The proposed operational structure would reduce posts by 10.82 funded whole time equivalent (WTE), generating an estimated saving of £754k against the Month 2 (May 2026) General Ledger budget. However, the proposed corporate structure would increase by an estimated 6.29¹ WTE with an overall estimated cost of £1.96m against the Month 2 (May 2026) General Ledger budget.
- There is a net decrease of 4.53 WTE with an overall forecast financial cost of £1.20m against the current funded establishment in the General Ledger, at Month 2 2026/27. This reflects the funding shortfall where some posts in scope do not appear to be funded in full to meet the budgeted WTE, when costing the posts at top increment².

¹ Change to the corporate structure noted on 10 August 2026 with a net increase of 1.00 WTE costing £114,611 following other adjustments notified to Finance.

² Finance Directorate FDP05 - LOCAL STANDARD OPERATING PROCEDURE ON BUDGETARY MOVEMENTS (VIREMENTS) Costing of skill mix changes need to be at top increment to ensure that sufficient funding is available to meet future commitments.

- The proposed structure includes a number of posts that were previously removed as part of the 2022/23 Operating Model and under the Voluntary Early Release Scheme. As these changes were supported by business cases approved by the Health Board and Welsh Government, it is unclear whether these can be reintroduced without further approval and justification.

Our review of the previous operating model implementation estimated it had cost £1,857,819³ more than stated.

Key Findings		Risk & Impact	Agreed Management Action
4	Workstream governance and monitoring of benefits realisation Workstream governance arrangements are not sufficiently documented – there are no Terms of Reference in place, or minutes for any of the Workstream meetings. We found that the Strategy workstream ceased operating on 29 April 2026, however we could not find evidence to confirm that this had been formally considered and approved by the Programme Board. We are unable to confirm that the forecast benefits from the Programme, delivered through the Workstreams, are subject to regular review, monitoring or challenge.	There is a risk that the Programme Board does not receive assurance from the Workstreams, leading to undocumented decisions being taken outside delegated authority.	Agreed Action: <ul style="list-style-type: none"> • Formalise Workstream governance arrangements through approved Terms of Reference. • Implement a consistent approach to recording key decisions, actions, risks and escalations across all Workstreams. • Develop and implement a benefits realisation framework, including benefit measures, ownership and reporting arrangements.
		High Priority	Expected Evidence of Implementation: <ul style="list-style-type: none"> • Workstream operate within delegated authority ensuring that the benefits of the Programme are at the fore. • Approved Workstream Terms of Reference. • Consistent approach to recording decisions, actions and escalations implemented across Workstreams. • Benefits realisation framework developed and reported through programme governance arrangements. • Benefits ownership and reporting arrangements established.
	Theme: Governance	Control Operation	Officer: Programme Director / Programme Manager / Workstream Leads Target Implementation Date: 31 st December 2026
5	Delivering within financial resources available Executive and Corporate Directors have reviewed the current structure and proposed a new organogram and organisational model. Our review identified potential risks arising from the proposed arrangements, including the creation of new posts prior to	There is a risk that a revised structure reintroduces/re-bands posts previously removed or downgraded through the	Agreed Action: <ul style="list-style-type: none"> • Continue to assess the financial implications, workforce impacts and affordability of organisational design proposals once the final structure is agreed post-consultation. • Following completion of consultation and prior to implementation of the final organisational model, undertake a dedicated review of all proposed new posts, re-banded

³ Source: Final Internal Audit Report: Operating Model (BCU-2324-33) issued in May 2024.

<p>completion of consultation and the potential reintroduction or regrading of posts previously removed through the Operating Model review and Voluntary Early Release Scheme. These previous structural changes were supported by business cases approved by the Welsh Government and the Remuneration and Terms of Service Committee.</p>	<p>Voluntary Early Release Scheme without sufficient evidence that this delivers value for money.</p>	<p>posts and posts that are equivalent or comparable to roles previously removed through the Voluntary Early Release Scheme (VERS).</p> <ul style="list-style-type: none"> • Ensure that any proposed new, re-banded or VERS-equivalent posts are supported by a clear justification, demonstrate value for money, and align with organisational requirements and affordability constraints. • Present the outcome of this review to the Executive Committee and appropriate governance groups for formal scrutiny and approval prior to implementation. • Obtain all required approvals through established governance processes before any structural changes are implemented.
<p>Theme: Finance Management & Control</p>	<p>High Priority</p> <p>Control Operation</p>	<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Comprehensive schedule and review of all proposed new posts, re-banded posts and VERS-equivalent posts. • Documented assessment of organisational need, affordability, workforce impact and value for money for affected posts. • Financial assessments completed for proposed structural changes. • Business cases developed and approved where required. • Minutes, papers and decision logs demonstrating review and scrutiny by the Executive Committee and relevant governance groups. • Evidence of governance approval and affordability review prior to implementation of the final organisational structure.
		<p>Officer: Senior Responsible Officer / Executive Director of Finance</p> <p>Target Implementation Date: 31st March 2027</p>

Objective 3: There is reporting to the Health Board/Committee on performance of the Programme.

Limited

Overview / Summary of Observations

The People and Culture Committee Terms of Reference (ToR) specifically state its role in providing assurance to the Board of the FftF Programme.

The draft FftF Programme Board ToR and Operating Arrangements state *"The Programme Board, assisted by the Programme Director, reports to the BCUHB Executive Committee via the Senior Responsible Owner and the People and Culture Committee on behalf of the Board"*, with the additional clarity provided at paragraph 9.2 *"The Programme Board will: Provide assurance to the People and Culture Committee through a regular report on progress."*

While verbal updates, presentations and papers were presented to the Health Board and other Committees in this period, these have not been considered as providing formal assurance. This is because the Board has specifically delegated responsibility for oversight and assurance of the Programme to the People and Culture Committee.

Key Findings		Risk & Impact	Agreed Management Action
6	Reporting to the People and Culture Committee Reviewing the agenda items for the People and Culture Committee from 19 December 2024 to 11 June 2026 inclusive, eight agenda items were identified; five (62%) provided verbal updates with three (38%) including papers for scrutiny. The reliance on verbal updates limits the Committee's ability to effectively scrutinise programme progress and challenge key issues, as members are unable to review information in advance of meetings or prepare informed questions. The absence of supporting papers reduces the audit trail available to demonstrate the information considered by the Committee, with meeting minutes providing only a high-level summary rather than a comprehensive and permanent record of the matters reported and discussed.	There is a risk that the People and Culture Committee cannot effectively scrutinise and challenge the Programme, and therefore fulfil its delegated remit to the Board, due to limited information presented.	Agreed Action: <ul style="list-style-type: none"> Continue to provide a standard written reporting approach to support bi-monthly updates to the People and Culture Committee. Continue to provide updates and written reports to the Health Board as necessary. Ensure reporting provides a consistent summary of programme progress, risks, benefits, delivery status and key decisions. Review reporting arrangements periodically to support effective scrutiny and assurance.
		High Priority	Expected Evidence of Implementation: <ul style="list-style-type: none"> Reports are presented to Committee for consideration. Standard reporting template adopted. Bi-monthly reports routinely submitted to the People and Culture Committee. Programme progress, risks, benefits and key decisions consistently included within reporting.
Theme: Reporting		Control Operation	Officer: Programme Director / Programme Manager Target Implementation Date: 31 st October 2026

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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



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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.



Health & Safety Compliance

Final Internal Audit Report

2026/27

Betsi Cadwaladr University Local Health Board



Limited Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

BCU-2627-03

July - August 2026

2 October 2026

October 2026

Stuart Keen, Director of Environment and Estates

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

To review compliance with HS01 Occupational Health and Safety Policy, assessing the adequacy of management arrangements for Health & Safety to provide assurance to the Health Board.

Overview

The Corporate Health and Safety Department has continued to strengthen health and safety arrangements. The 2025 annual self-assessment process provides a clearer and more structured framework for assessing compliance, identifying areas for improvement, and reinforcing accountability across services.

The planned implementation of a new electronic system is expected to further strengthen monitoring, reporting and communication arrangements.

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

- Governance and attendance: Strategic Occupational Health and Safety Group meetings reviewed were not quorate in accordance with the Terms of Reference, and attendance at IHC Health and Safety Groups was inconsistent across some services.
- Communication and follow-up: Communication supporting the Health and Safety self-assessment process, and dissemination of review outcomes, was not consistently effective across some operational services and departments.
- Policy alignment: A review of the policy is required to ensure section 5, BCUHB General Arrangements for Health and Safety, reflects current operating arrangements and any changes arising from implementation of the new Power App system.
- Role-specific training: Quarterly reports indicate that a small number of services continue to have limited engagement with role-specific health and safety training, suggesting that Training Needs Analyses are not being consistently used to identify and address staff training requirements.

Although the Health Board may have appropriate systems, processes and controls in place, the effectiveness of these arrangements ultimately depends on uptake/implementation from all Divisions/Directorates and the services that underpin them.

Future Considerations

The Foundations for the Future programme may impact health and safety governance arrangements considered as part of this review. Organisational and service change arising from the programme has the potential to alter reporting lines, governance structures, local group membership, and management responsibilities. Consequently, findings from this audit should be considered within the context of the ongoing transformation programme.

Scope & Assurance Summary

Objectives <small>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.</small>		Related Findings	Assurance
1	Determine whether robust governance, leadership and accountability arrangements for Health & Safety are in place and functioning effectively.	1,2	Limited
2	To assess whether monitoring and assurance processes effectively support compliance, learning and continuous improvement of the Health and Safety.	3,4	Limited
3	Health and Safety training is delivered in line with requirements, with compliance routinely monitored and actions taken to address any shortfalls.	5	Reasonable

Management Actions

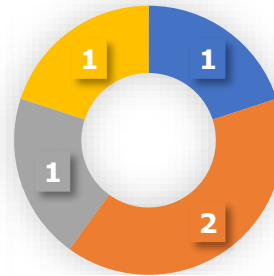


High Priority



Medium Priority

Themes



- Communication & Engagement
- Governance
- Policies & Procedures
- Training & Development

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

At a glance – Role specific Health and Safety Training attendance for 1 April 2025 to 31 March 2026

HS01 Health and Safety Policy, Section 5.1.5 – Roles Specific to Health and Safety Training states, *"This training will be identified by Managers and provided to employees/workers as a direct result of the training needs analysis and the risk assessment process."*

The figures reported below, record the number of staff who have been identified by line managers and received the role-specific training required to perform their duties safely and effectively within their respective Directorate/Service.

Table 1: Health and Safety Annual figures for Role Specific Training 2025- 2026

Course	Cancer services	Corporate Services	Environment and Estates	IHC Central	IHC East	IHC West	MHLD	Midwifery and Women's	Diagnostic & Clinical	Yearly Total
Risk Assessment Made Easy	0	35	9	44	42	51	17	2	21	221
COSHH Awareness	2	29	8	53	54	59	13	4	18	240
RIDDOR Awareness	0	43	8	39	30	48	15	4	23	210
NEBOSH Health and Safety at Work Award	0	29	8	27	11	43	12	4	9	143
Mandatory Health and Safety Training (Classroom)	0	0	0	13	5	4	0	0	0	22
HS01 Health and Safety Self-Assessment Toolbox Talk	1	41	3	45	12	55	5	5	10	177
Environmental Ligature Awareness Training*	0	12	0	7	4	3	185	3	0	214
Bespoke	0	0	12	6	19	26	0	0	0	63
TOTAL	3	189	48	234	177	289	247	22	81	1,290

Source: Pan-BCUHB Health, Safety and Security Performance Reports

Findings & Agreed Action Plan

Objective 1: Determine whether robust governance, leadership and accountability arrangements for Health & Safety are in place and functioning effectively.	Limited
---	----------------

Health & Safety Policy HS01 2024-27 establishes a framework for managing health and safety, including risk assessment, incident reporting, training, and continuous improvement using a “Plan, Do, Check, Act” approach. The policy also defines roles and responsibilities at all levels, outlines governance and reporting arrangements, and explains how compliance is monitored through audits, inspections, and performance reporting.

The People and Culture Committee receive assurance from Strategic Occupational Health and Safety Group (SOHSG) in accordance with the Committee’s cycle of business i.e. two reports per annum including the annual health and Safety report. Section 9 of the SOHSG Terms of Reference (Reporting and Assurance Arrangements) indicates an expectation for more formalised reporting arrangements.

The Strategic Occupational Safety and Health Group meets bi-monthly, and the three latest sets of minutes reviewed (December 2025, February 2026, and April 2026 with June 2026 being stood down).

Local H&S groups

Our review of the Health & Safety (H&S) governance arrangements across Central, East and West Integrated Health Communities (IHCs) identified evidence of H&S safety groups providing oversight of health and safety risks.

Across all three IHCs, common themes included fire safety and emergency preparedness, health and safety compliance, workforce competency and training, security and violence and aggression, environmental and estates-related risks, and the management of operational health and safety risks.

Key Findings		Risk & Impact	Agreed Management Action
1	Strategic Occupational Health and Safety Group All three SOHSG meetings reviewed were not quorate in line with terms of reference paragraph 7.1.1 <i>At least ½ of members (one of which must be the Chair or Vice Chair and must include at least one representative of occupational health and safety and one representative of Acute or Area or Mental Health), together with trade Union partners must be present to ensure the quorum of the Group.</i>	That key risks and issues may not be adequately scrutinised where required professional representatives are absent or decisions lack legitimacy.	Agreed Action: The SOHSG suffers from poor attendance due to competition with other meetings. Consequently, the corporate fit of the group should be reviewed and then the Terms of Reference updated to reflect reporting and membership as well as potentially revising the quoracy requirements.
		High Priority	Expected Evidence of Implementation: Approved Terms of Reference and improvements in quoracy for future meetings.
	Theme: Governance	Control Operation	Officer: Director of Environment and Estates Target Implementation Date: 31/03/2027

2	IHC H&S Groups Health and safety risks are being identified, monitored and escalated through established governance arrangements across the three IHCs; however, attendance at these meetings was poor among representatives from certain services.	Poor service representation and inconsistent reporting result in inadequate oversight of operational health and safety risks.	Agreed Action: The Local Health and Safety groups should be reviewed in response to action 1 above, and then the Terms of Reference updated to reflect reporting and membership as well as potentially revising the quoracy requirements.
			Expected Evidence of Implementation: Approved Terms of Reference and improvements in quoracy for future meetings.
		High Priority	Officer: Director of Environment and Estates and then Respective Divisional Directors of Operations and their equivalents in other Divisions/Directorates Target Implementation Date: 30/09/2027
	Theme: Governance	Control Operation	

Objective 2: To assess whether monitoring and assurance processes effectively support compliance, learning and continuous improvement of the Health and Safety.

Limited

The Health and Safety Self-Assessment template was updated to align with legal requirements, guidance, and the NHS Employer Health and Safety Standards, supporting the Health Board's compliance with health and safety legislation. The 2025 assessment cycle marked the first phase of the transition to this new standards-based approach.

The Health and Safety Self-Assessments are completed through two assessment cohorts during the year. Cohort 1, undertaken in April, comprises the East, Central and West Integrated Health Communities (IHCs), Environment and Estates, Radiology, and Mental Health and Learning Disabilities (MHL) services. Cohort 2, undertaken in October, comprises Cancer Services, Women's and Maternity Services, Community Services, Pan Services, Corporate Services, and Primary Care.

Responsibility for completing and maintaining the self-assessment rests with individual service sectors, with Directors accountable for ensuring completion and ongoing oversight within their areas of responsibility.

Following submission of the self-assessments, Corporate Health and Safety identify a sample of areas for validation to provide assurance that the assessments had been completed accurately. These are selected using a series of set parameters driven by responses and scores.

As part of the review, we sampled nine services to determine whether self-assessments and Corporate Health and Safety reviews had been undertaken, as well as whether departmental health and safety files were maintained.

The review identified that Health & Safety arrangements are generally well established across the areas visited, with evidence available to demonstrate that self-assessments, risk assessments, COSHH assessments, local inductions and routine Health & Safety inspections are being undertaken. As the process was introduced in 2025, annual completion of self-assessments, supported by Health and Safety Department review, will help build a dataset to identify, monitor and track compliance trends, improvement areas and organisational learning over time.

The following is a comparison of 2025 and 2026 self-assessment return rates to identify any reduction in participation.

2025-26 Self-Assessment Returns – Cohort 1							
Estates and Environment	IHC Central Acute	IHC East Acute	IHC West Acute	MHLD	Radiology	Corporate (non requested)	Total
1	34	26	43	47	1	3	155
2026-27 Self-Assessment Returns – Cohort 1							
3	28	8	14	45	1	-	99

The review of the data has noted an overall decline in returns equating to around one third, with significant deterioration from both the IHC East Acute, and West Acute areas. We were informed that any areas who had not returned their self-assessments in the first cohort of the year will be picked up when the second cohort is sent out towards the end of the year; however this relies upon the Corporate Health and Safety Team's ability to utilise the electronic self-assessment referenced below and the availability of an agreed Master Location Register.

A Power App is currently being developed and is due to be introduced for the second cohort in 2026. The system will provide greater oversight and scrutiny of the process by enabling data to be broken down by ward and department, supported by a live dashboard (under development by Digital, Data and Technology) displaying key performance metrics. It will also facilitate identification of learning opportunities through analysis of variances between self-assessments and Health & Safety reviews, highlight areas of poor performance where self-assessments are not being completed consistently, track outstanding actions, and issue automated email reminders for overdue actions.

Key Findings		Risk & Impact	Agreed Management Action
3	<p>Self-assessments and health and safety reviews</p> <p>Our sample found that communication arrangements within some services/departments was not being disseminated supporting the Health and Safety self-assessment.</p> <p>Key information is not always reaching the appropriate staff, reducing assurance that self-assessments and resulting actions are being effectively managed and progressed.</p> <p>There is an overall reduction of 33% in returns for Cohort 1 2025 in comparison to Cohort 1 2026.</p>	<p>There is a risk that communication may not be received or acted upon by appropriate staff, leading to weaknesses in Health and Safety oversight, action tracking and risk management.</p>	<p>Agreed Action: Divisions and Directorates, supported by Corporate Health and Safety, will review and confirm the services and officers responsible for completing Health and Safety self-assessments and implement a Master Location Register. The Register will be reviewed and updated by the Divisions and Directorates prior to each self-assessment cycle to ensure communications, self-assessments and associated action plans are directed to the appropriate responsible officers and locations.</p> <p>The Master Location Register is designed to ensure accountability is assigned to appropriate officers, communication arrangements are effective, and self-assessments and associated action plans are being appropriately managed and progressed.</p> <p>Expected Evidence of Implementation:</p> <p>Review of officers undertaking self-assessments by management in partnership with corporate Health and Safety department.</p>
		High Priority	

	Theme: Communication & Engagement	Control Operation	Officer: Head of Health, Safety and Security together with respective Divisional Directors of Operations and their equivalents in other Divisions/Directorates. Target Implementation Date: 31/03/2027
4	Health and Safety Policy HS01 Health Board policy reflects the Plan, Do, Check, Act and Learn approach to health and safety management, but this does not appear reflective of current practice e.g. new standard self-assessment and Health and safety reviews is not reflective of Section 5.3.1 Audit.	The Health and Safety Policy may not accurately reflect current operating arrangements. Medium Priority	Agreed Action: Policy upon review will align with current practice. Expected Evidence of Implementation: Approved Policy. Officer: Director of Environment and Estates Target Implementation Date: 26/09/2027 (based upon when the policy review is next due).
	Theme: Policies & Procedures	Control Design	

Objective 3: Health and Safety training is delivered in line with requirements, with compliance routinely monitored and actions taken to address any shortfalls.

Reasonable

Health and Safety mandatory training compliance remains above the Health Board's target of 85%, with overall compliance for 2025-26 recorded at 90%.

Role-specific health and safety training is delivered by the Corporate Health and Safety Department. In accordance with Section 5.1.5 of the HS01 Health and Safety Policy, managers are responsible for undertaking a Health and Safety Training Needs Analysis (TNA) to ensure that staff receive the role-specific training required to perform their duties safely and effectively within their respective departments. However, evidence for 2025-2026 indicates consistently low levels of attendance from some services.

Training for managers is supported through the delivery of the National Examination Board in Occupational Safety and Health (NEBOSH) Health and Safety at Work Award. Performance data indicates positive engagement with this programme, with a total of 143 attendees recorded. Attendance at this training offer has shown a consistent upward trend across successive reporting periods. We were informed that the Corporate Health and Safety Department is also in the process of coordinating the delivery of the NEBOSH Certificate qualification. Given the associated costs, a recruitment process is being established to ensure that suitable staff are selected to attend the course.

Key Findings	Risk & Impact	Agreed Management Action
Health and Safety Training Needs Analysis – Role Specific Training Annual attendance reports indicate that a small number of services continue to show limited engagement with role-specific	Limited engagement with role-specific health and safety training	Agreed Action: Health and Safety Training Needs Analysis to be developed with consultation at Strategic Occupational Safety and Health Group and approval by People and Culture Committee.

<p>health and safety training.</p> <p>This indicates that Training Needs Analyses (TNAs) is not being undertaken to identify and address the specific training requirements of staff across certain services.</p>	<p>may reduce assurance that staff have the necessary competence to manage health and safety risks, increasing the likelihood of non-compliance, unsafe practice and unaddressed hazards within services.</p>	<p>Expected Evidence of Implementation:</p> <p>Increased attendance and engagement figures for role-specific health and safety training within services previously reporting low participation.</p>
<p>Theme: Training & Development</p>	<p>High Priority</p> <p>Control Operation</p>	<p>Officer: Director of Environment and Estates (TNA Development) in collaboration with respective Divisional Directors of Operations and their equivalents in other Divisions/Directorates (Operational Implementation).</p> <p>Target Implementation Date: 31/03/2028</p>

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.
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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.
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Integrated Medium Term Plan (IMTP) and Annual Plan Internal Audit Report 2026/27

Betsi Cadwaladr University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

BCU-2627-07

July - September 2026

5 October 2026

October 2026

Executive Director of Transformation and
Strategic Planning

Dave Harries, Head of Internal Audit
Nicola Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

We reviewed the process undertaken for the development of the Integrated Medium-Term Plan (IMTP) and Annual Delivery Plan, including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.

Overview

There is a documented timetable in place for the drafting, review and approval of the IMTP and Annual Delivery Plan, which is in line with national requirements. However, internal timescales were shortened in 2026/27 due to capacity issues, which has impacted on how staff felt they were engaged with throughout the process. We issued a questionnaire to senior staff involved in the development of the IMTP and Annual Plan; themes from the feedback include late engagement, weak communication, limited ownership of objectives, and concerns about deliverability and accountability. We recognise that this feedback has likely been affected by the shortened timescales.

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

- Planning timetable: The compressed planning cycle and movement of internal deadlines reduced the time available for robust review, challenge and integration of the plan.
- Engagement and ownership: Inconsistent engagement with staff responsible for delivery may weaken ownership of actions and reduce the extent to which operational insight informs the final plan, and result in undeliverable objectives.

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

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	To assess whether the IMTP and Annual Delivery Plan are developed in line with NHS Wales Planning Framework requirements, including key timelines and required components.		1	Reasonable
2	To evaluate the extent and effectiveness of engagement with executives, directors, staff, and stakeholders in the development of the IMTP and Annual Plan.		2	Limited
3	To review whether appropriate arrangements are in place to monitor delivery of the IMTP and Annual Plan, including reporting to relevant groups, committees, and the Board.		-	Reasonable

Management Actions

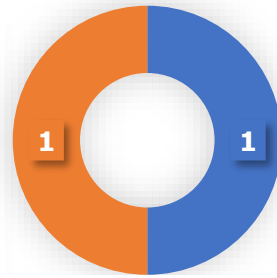


High Priority



Medium Priority

Themes



■ Communication & Engagement

■ Resourcing

Risk Types

Quality or Safety Issues

At a glance - Engagement Questionnaire: Response messages

We issued a questionnaire to all staff involved with the development of the IMTP. In total we issued the questionnaire to 120 staff members and received 45 (38%) responses. The main themes raised from the questionnaire were:

Theme	Survey Message
Stakeholder engagement	Too many respondents felt involved late or not at all
Communication	Communication often unclear, repetitive or rushed
Ownership of objectives	Objectives changed or assigned without consultation
Accountability	Lack of clarity around leads and delivery ownership
Deliverability	Concerns about realism, workload and resources
Integration of planning	Finance, workforce and operational planning not always aligned

Findings & Agreed Action Plan

Objective 1: To assess whether the IMTP and Annual Delivery Plan are developed in line with NHS Wales Planning Framework requirements, including key timelines and required components.

Reasonable

Overview / Summary of Observations

A documented planning timetable and process was in place for development of the 2026–29 IMTP and Annual Delivery Plan. The process covered service-level planning, submission and review of service plans, development and refinement of the three-year plan, governance review and final Board consideration. Service-level plans were submitted in November and December 2025, with further review and refinement continuing through January and February 2026. The final plan was considered by the Board on 26 March 2026 and submitted to Welsh Government within the required timescale.

The internal timescales for the planning cycle were shortened due to capacity issues - the interim postholder took responsibility in September/October 2025, at that point there was no established forward plan for developing the IMTP. A planning cycle covering October 2025 to March 2026 was then introduced. Some internal deadlines were adjusted because of capacity pressures so that the required governance and submission dates could still be achieved.

The final IMTP included strategic priorities, actions and deliverables, with the Annual Delivery Plan incorporated into year one. Welsh Government Delivery Expectations and Enabling Actions were mapped to the plan. Finance and workforce colleagues contributed to the planning process, and demand and capacity work was used to support activity and performance trajectories. National priorities and local population needs were also considered.

The Board supported submission of the three-year plan but could not approve a financially balanced IMTP because the plan remained in deficit; adopting a deficit IMTP financial plan is a breach of Standing Financial Instruction 4.3.8 (b).

Key Findings		Risk & Impact	Agreed Management Action
1	<p>Planning Timetable</p> <p>The planning cycle was compressed and some internal deadlines changed, which reduced the time available for review and challenge. However, the main planning stages were completed and the final external submission deadline was achieved.</p>	<p>A compressed planning cycle may reduce the time available to integrate, review and challenge plans, increasing the risk of incomplete or insufficiently developed plans.</p>	<p>The compressed planning timescales experienced during the 2026/27 planning round reflected exceptional circumstances, including transition of responsibility for the planning function and the absence of an established forward planning cycle. A continuous annual planning cycle has now been established to support earlier commencement of planning and greater stability in the development of future IMTPs.</p> <p>Agreed Action:</p> <ol style="list-style-type: none">1) Develop and issue IMTP Planning Guidance for the 2027-30 planning cycle, setting out key milestones, responsibilities, governance arrangements and submission requirements.2) Develop and communicate a detailed planning timetable to Directorates and planning leads to support timely development, review and challenge of plans.

			3) Monitor progress against the planning timetable through established planning governance arrangements.
			Expected Evidence of Implementation: Approved annual planning cycle (July 2026) <ul style="list-style-type: none">Published IMTP Planning Guidance and Planning Pack issued to Directorates (30 November 2026)Documented planning timetable and tracker (30 November 2026)
		Medium Priority	Officer: Assistant Director Corporate Planning (Interim) Target Implementation Date: 30 November 2026
Theme: Resourcing		Control Design	

Objective 2: To evaluate the extent and effectiveness of engagement with executives, directors, staff, and stakeholders in the development of the IMTP and Annual Plan.

Limited

Overview / Summary of Observations

Engagement took place through planning meetings, workshops, one-to-one discussions, planning huddles (involving internal planning leads and corporate representatives from across the Health Board), written requests for input and existing governance and stakeholder forums. There was no formal engagement plan for the 2026/27 cycle. The questionnaire provides a mixed view of how well this worked in practice. Of the 45 respondents, a high percentage (49%) rated their overall involvement as limited or poor, and some (38%) aware of objectives, actions or commitments that had been assigned to their area without sufficient discussion or agreement. Most respondents (80%) considered that senior management engagement should be strengthened.

Communication was also a concern, with 49% of respondents disagreeing that communication about the planning process was timely and clear, while 44% disagreed that they received clear communication about the input required. Only 29% agreed that their input was requested before key decisions were finalised.

A comparison by seniority shows that Directors had a less favourable view on most engagement measures. Across the communication and involvement statements, 45% of senior director responses were negative compared with 26% for other respondents, while 31% were positive compared with 46% for other respondents. Directors were less positive on 13 of the 14 statements.

Senior Directors were also more likely to disagree that relevant operational, clinical, financial and workforce leads were involved, and that the process was collaborative. Ninety-three per cent (93%) considered that senior management engagement should be strengthened, compared with 73% of other respondents.

Key Findings		Risk & Impact	Agreed Management Action
2	Engagement and ownership Engagement took place, but the questionnaire, issued to staff involved with the IMTP, identified significant concerns around involvement, communication and ownership. Feedback from 45 staff was: <ul style="list-style-type: none"> - 49% rated their involvement as limited or poor - 80% considered senior management engagement should be strengthened. Whilst the control exists, the effectiveness is inconsistent.	Inconsistent engagement may result in plans that lack ownership, operational insight or agreement from those responsible for delivery.	Whilst engagement was undertaken through a range of planning meetings, governance forums and stakeholder discussions, opportunities have been identified to strengthen the consistency, visibility and coordination of engagement throughout the planning process. A more structured approach to engagement will be implemented as part of the 2027-30 IMTP development cycle. Agreed Action: <ol style="list-style-type: none"> 1) Develop and implement an IMTP Engagement and Communications Plan to support development of the 2027-30 IMTP, recording engagement activity contributing to the plan development. 2) Launch the IMTP Planning Guidance and Planning Pack through Directorate Senior Leadership Teams and Management Teams during October and November 2026.
			Expected Evidence of Implementation: <ul style="list-style-type: none"> • IMTP Engagement and Communications Plan. • Records of presentations delivered to Directorate Senior Leadership Teams and Management Teams. • Evidence of planning workshops, meetings and engagement sessions undertaken during IMTP development.
	Theme: Communication & Engagement	<div>High Priority</div> Control Design	Officer: Assistant Director Corporate Planning (Interim) Target Implementation Date: 30 November 2026 (Engagement Plan implemented)

Objective 3: To review whether appropriate arrangements are in place to monitor delivery of the IMTP and Annual Plan, including reporting to relevant groups, committees, and the Board.

Reasonable

Overview / Summary of Observations

Arrangements are in place to monitor delivery of the Annual Delivery Plan and to report progress through management, Committee and the Board. During 2025/26, formal progress reporting was undertaken quarterly. Reports were considered through Strategic Planning and Service Change Group (SPSCG), Planning Population Health and Partnerships (PPHP) Committee, Performance, Finance and Information Governance Committee, and the Health Board, with quarterly reports presented to the Board during the year. For 2026/27, monthly reporting was introduced alongside formal end-of-quarter reporting to provide earlier information on delivery status and areas requiring attention.

Progress reports included updates against objectives and deliverables, delivery confidence ratings and narrative commentary on areas where delivery was off track. SPSCG was used as an early review point before reports progressed through formal governance, allowing Executive leads to review the content, provide clarification and request changes. There was also the opportunity to raise and/or escalate specific delivery concerns for Executive consideration or intervention.

Risk reporting was less consistent during 2025/26. Risks and issues were not routinely captured as a separate reporting requirement and were instead included within narrative updates where relevant. This limited the consistency with which delivery risks could be identified, compared and tracked across the plan. The 2026/27 reporting arrangements have been strengthened; the reporting portal now contains a field for risks and constraints, monthly reports provide more frequent oversight, and work is underway to link the Board Assurance Framework more closely with the Annual Delivery Plan reporting. These changes address the main weakness identified, although the revised arrangements were relatively new at the time of the review. Continued use of the risk field and clear escalation of significant delivery risks will be important to ensure the strengthened process operates consistently.

Appendix A

Question	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Assurance % ¹
I understand the purpose of the IMTP and Annual Plan	51%	40%	5%	0%	4%	96
I was aware of the timetable and key milestones for developing the plan	22%	40%	16%	13%	9%	78
I received clear communication about what input was required from me	11%	27%	18%	35%	9%	56
I received sufficient guidance, templates or instructions to support my input	9%	15%	31%	36%	9%	55
Communication about the planning process was timely and clear	5%	24%	22%	40%	9%	51
I had sufficient opportunity to contribute to development of the IMTP/Annual Plan	7%	29%	27%	25%	13%	63
My input was requested before key decisions were finalised	9%	20%	25%	33%	13%	54
The right senior managers were involved in developing the plan	15%	38%	27%	18%	2%	80
Relevant operational, clinical, finance and workforce leads were involved	11%	23%	36%	28%	2%	70
I was able to challenge proposed objectives, actions or commitments	9%	29%	29%	27%	6%	67
Concerns or feedback raised during the planning process were listened to and considered	7%	24%	47%	13%	9%	78
The planning process was collaborative across relevant teams and services	13%	20%	31%	25%	11%	64
Staff responsible for delivery had appropriate input into the actions assigned to them	7%	31%	35%	18%	9%	73
Overall, I was appropriately involved in developing the IMTP/Annual Plan	9%	28%	29%	29%	5%	66
The objectives and actions assigned to my area are realistic	2%	47%	35%	7%	9%	84
The objectives and actions can be delivered within the required timeframe	2%	42%	31%	20%	5%	75
Financial, workforce and operational constraints were sufficiently considered	0%	22%	35%	36%	7%	57
Key risks and dependencies affecting delivery were adequately identified	0%	20%	44%	29%	7%	64
There was appropriate challenge over whether proposed actions were deliverable	0%	22%	47%	24%	7%	69
I was asked to confirm whether my area had the resources, capacity and capability to deliver the actions assigned	0%	11%	40%	33%	16%	51
Accountability for delivery of IMTP/Annual Plan actions is clear	4%	36%	11%	40%	9%	51
I understand the actions and targets that my area is expected to deliver	13%	49%	29%	9%	0%	91
Named owners or responsible leads for actions are clearly identified	16%	36%	18%	29%	2%	70
Arrangements for monitoring, escalation and oversight of delivery are clear	6%	31%	29%	27%	7%	66

¹ Green - 70% or more of responses were positive / neutral

Amber - 60 – 69% of responses were positive / neutral

Red - less than 60% of responses were positive / neutral

Question	Response	Assurance
Are you responsible for any actions, objectives or commitments within the IMTP/Annual Plan?	Yes 73% · No 23% · Not sure 4%	N/A
At what stage(s) were you involved in developing the IMTP/Annual Plan?	Initial priorities 29% · Directorate objectives 47% · Planning assumptions 20% · Risk assessment 13% · Draft review 36% · Final agreement 29% · Informed after agreement 29% · Not involved 9% · Other 9%	N/A
How were you involved in the development of the IMTP/Annual Plan?	Planning meetings 52% · Written input 50% · Draft review 41% · Directorate discussions 32% · 1:1 discussion 32% · Workshops 25% · Governance groups 25% · Not involved 11% · Other 5%	N/A
Were any objectives, actions or commitments assigned to your area without sufficient discussion or agreement?	Yes 38% · No 42% · Not sure 20%	62
How would you rate your overall level of involvement in developing the IMTP/Annual Plan?	Very good 7% · Good 22% · Adequate 22% · Limited 33% · Poor 16%	51
How confident are you that the actions assigned to your area are realistic and deliverable?	Very confident 4% · Fairly confident 36% · Neither 23% · Not very confident 23% · Not confident 7% · N/A 7%	63
Do you think senior management engagement in the planning process should be strengthened?	Yes 80% · No 7% · Not sure 13%	20

Appendix B

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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

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

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Suicide Prevention

Internal Audit Report

2026/27

Betsi Cadwaladr University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

BCU-2627-18

June – August 2026

6 October 2026

October 2026

Teresa Owen, Executive Director of Allied Health Professionals and Health Science

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

To identify the steps being taken in the Health Board to support the implementation of the Welsh Government prevention and self-harm delivery plan, and how this is reported through for assurance.

Overview

The Health Board supports suicide prevention through a regional, multi-agency approach aligned to the Welsh Government strategy. Appropriate governance arrangements, delivery activity and use of data are established, with the Health Board actively contributing to regional forums, targeted prevention work and learning from incidents. There are opportunities to strengthen local leadership for suicide prevention, planning and reporting to support Health Board-level assurance. We have concluded reasonable assurance on this area.

The matters requiring management attention include:

- The Health Board has not clearly identified a single lead with overall responsibility for coordinating suicide prevention activity and providing assurance regarding the Health Board’s contribution to delivery of the regional plan.
- Suicide prevention information is available across several regional and internal reports, however it is not consolidated into a single report to provide comprehensive oversight of performance, progress against objectives, risks and delivery of planned actions.

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

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	To assess whether the Health Board has appropriate arrangements in place to deliver the Welsh Government Suicide Prevention Strategy and Delivery Plan.		1,2	Reasonable
2	To evaluate whether suicide prevention activities are effectively delivered across the Health Board and whether opportunities to enhance or maximise impact are identified and acted upon.		-	Reasonable
3	To review how suicide prevention activity and outcomes are monitored and reported to provide assurance to the Board.		3	Limited



At a glance – Deaths by suspected suicide

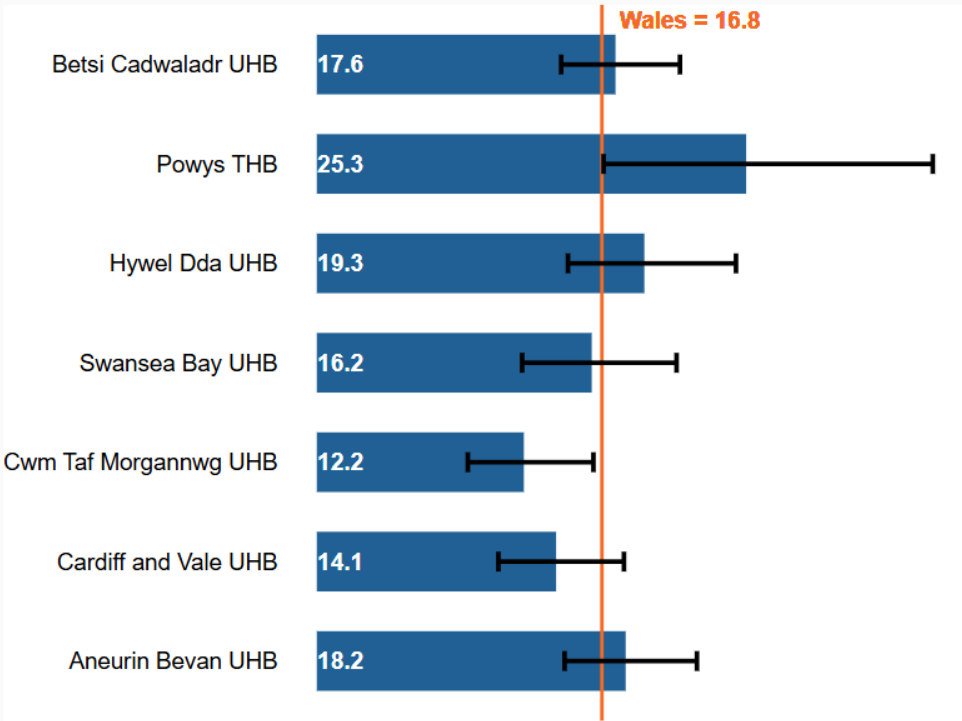
Deaths by suspected suicide, by health board area of residence

Deaths by suspected suicide 2024 to 2025' shows that deaths by suicide in Betsi Cadwaladr Health Board were higher than the all Wales rate, but they were not 'statistically significantly higher':

Deaths by suspected suicide, by health board area of residence

Figure 3. Deaths by suspected suicide, by health board area of residence, crude rate per 100,000 residents, 2024/25

Produced by Public Health Wales, using RTSSS data and MYE (ONS)



Source: Public Health Wales Figure 3: [Deaths by suspected suicide 2024 to 2025 - Public Health Wales](#)

Local authority of residence death by suspected suicide within the Health Board area

Deaths by suspected suicide, by local authority of residence, crude rate per 100,000, Welsh residents, 3-year period, 2022/23 to 2024/25:

Insights from April 2022 to March 2025 data

Local authority of residence

Figure 13. Deaths by suspected suicide, by local authority of residence*, crude rate per 100,000, Welsh residents, 3-year period, 2022/23 to 2024/25

Produced by Public Health Wales, using RTSSS data



Source: Public Health Wales Figure 13 [Deaths by suspected suicide 2024 to 2025 - Public Health Wales](#)

Findings & Agreed Action Plan

Objective 1: To assess whether the Health Board has appropriate arrangements in place to deliver the Welsh Government Suicide Prevention Strategy and Delivery Plan.	Reasonable
---	-------------------

Overview / Summary of Observations

The Health Board has arrangements in place to support delivery of the Welsh Government Suicide Prevention and Self-harm Strategy and Delivery plan. There are no specific key performance indicators included in the strategy and plan for Health Boards. Delivery is mainly through the North Wales Multi-Agency Suicide Prevention and Self-harm Action Plan 2025–2028, rather than a separate Health Board-only plan. The regional plan is structured around the six national objectives, includes actions, timescales and responsible partners, and is aligned to the national three-year delivery period. The July 2026 version also includes an end-of-year-one update against individual actions, giving a clear view of what has progressed and what remains in development. It states that quarterly updates will be provided through the regional arrangements, with highlights and issues reported onwards to the National Suicide and Self-harm Programme Board.

Governance is provided through the North Wales Regional Suicide and Self-harm Prevention Forum. Its Terms of Reference require quarterly meetings and reporting to the National Suicide and Self-harm Programme Board on activity, risks, learning and progress. Meeting records show that the Forum is active and considers the action plan, regional data, subgroup arrangements, risks and actions. The governance structure also includes subgroups covering under-served communities, empowering and equipping, support after suicide and a proposed Suicide and Self-harm Review Group. The Review Group had not been established at the time of the audit, although Terms of Reference had been drafted and discussions had taken place regarding leadership and governance.

The Health Board is represented across the regional arrangements, including Occupational Therapy, Clinical Psychology, Children and Adolescent Mental Health Services (CAMHS), Safeguarding, Public Health (within the Health Board), and other services. The Health Board is also a named statutory partner in the Conwy Suspected Suicide Rapid Response pilot, alongside the Local Authority and North Wales Police, providing further evidence of direct involvement in regional delivery arrangements. Given the highly integrated partnership arrangements within which this work is delivered, there can sometimes be challenges in distinguishing between organisational and partnership activity. Health Board specific activity was evident within the review, for example the Strategic Equality Plan (SEP) and patient safety activity.

Key Findings		Risk & Impact	Agreed Management Action
1	Leadership Suicide prevention activity is delivered across several Health Board services and through regional partnership arrangements. However, the evidence provided did not identify a designated Health Board lead with overall responsibility for coordinating suicide prevention activity, monitoring delivery and providing assurance on the Health Board's contribution to the regional plan.	Without clearly identified Health Board leadership, there is a risk that accountability for suicide prevention is unclear and activity is not consistently coordinated across services. This could result in gaps or duplication in delivery, actions and risks not being effectively	Agreed Action: The Health Board will appoint a Senior Responsible Officer (SRO) for Suicide Prevention and Self-Harm who will provide strategic oversight of the Health Board's contribution to the North Wales Multi-Agency Suicide Prevention and Self-Harm Action Plan. The Health Board will identify a governance framework for reporting of this activity, ensuring senior leadership oversight and alignment with the Mental Health partnership Board to ensure:

		monitored or escalated, and incomplete assurance being provided to senior management and the Board.	<ul style="list-style-type: none"> • Clear accountability for delivery of Health Board-specific actions. • Quarterly oversight of progress, risks, and performance. • Escalation of significant risks and issues through existing Quality, Safety and Experience governance routes. • Annual reporting to the appropriate Board Committee to provide organisational assurance.
		Medium Priority	<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Formal appointment of an SRO. • Approved governance structure and reporting route. • Named Health Board representatives responsible for delivery of the plan. • Quarterly reporting schedule established and evidenced through meeting agendas/minutes. • Documented risk escalation process. • Deliver effective staff communication and stakeholder engagement throughout implementation of the plan.
	Theme: Governance	Control Design	<p>Officer: MHLD Director of Mental Health or delegate until commencement in post.</p> <p>Target Implementation Date: 30 November 2026</p>
2	<p>Health Board actions</p> <p>Whilst the Health Board is supporting delivery of the regional Suicide Prevention and Self-Harm Action Plan, it has not developed a Health Board-specific implementation plan setting out its local priorities, planned actions, intended outcomes, responsible officers, timescales and monitoring arrangements. In addition, suicide prevention activities are not explicitly referenced within the Health Board's Integrated Medium Term Plan (IMTP).</p> <p>Although the regional plan contains overarching objectives and actions, the absence of a detailed local delivery plan limits the Health Board's ability to demonstrate how national and regional priorities are being translated into local action and monitored through established governance arrangements.</p>	<p>Without a Health Board-specific plan, with clearly defined local objectives, responsibilities, milestones and monitoring arrangements, the Health Board may be unable to demonstrate effective implementation of the Welsh Government Suicide Prevention and Self-Harm Strategy.</p> <p>This could result in inconsistent delivery of actions, inadequate oversight, failure to identify and address local priorities, and non-compliance with national requirements, potentially impacting the Health Board's</p>	<p>Agreed Action:</p> <p>A Health Board Suicide Prevention and Self-Harm Delivery Plan will be developed to clearly identify Health Board-specific priorities, actions, leads, milestones, outcome measures and reporting arrangements aligned to the North Wales Multi-Agency Suicide Prevention and Self-Harm Action Plan 2025-2028.</p> <p>The plan will be incorporated within existing planning and governance arrangements and reviewed quarterly to monitor delivery, risks, and emerging priorities.</p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Approved Health Board Suicide Prevention and Self-Harm Delivery Plan. • Named lead officer and delivery lead for each action with agreed timescales identified. • Defined milestones and reporting requirements. • Quarterly progress reports demonstrating delivery against planned actions.

		ability to reduce suicide and self-harm-related harm within its population.	<ul style="list-style-type: none"> Explicit alignment between Health Board actions and regional plan objectives.
		Medium Priority	Officer: SRO for Suicide Prevention and Self-Harm
	Theme: Planning, Delivery & Deadline Management	Control Design	Target Implementation Date: 31 January 2027

Objective 2: To evaluate whether suicide prevention activities are effectively delivered across the Health Board and whether opportunities to enhance or maximise impact are identified and acted upon.	Reasonable
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Overview / Summary of Observations

There is evidence of a broad range of suicide prevention activity across North Wales, with the Health Board contributing to several areas. The regional action plan tracks initiatives including the Suicide Prevention Protocol, awareness campaigns, training, support after suicide, rapid response arrangements and locations of concern. The July 2026 update records that the Suicide Prevention Protocol had been adopted and published, two locations-of-concern groups were operating, and the Conwy Rapid Response pilot had started in February 2026. It also records activity to improve awareness and support, including work with priority communities, training for staff and development of resources.

Evidence provided shows that gaps and improvement opportunities are being considered. Forum discussions have identified issues such as limited self-harm data and the need to strengthen subgroup arrangements. Themed work has also examined higher-risk groups including people affected by homelessness, domestic abuse, unemployment and contact with the criminal justice system. Data, research and lived experience are being used to identify barriers and possible improvements. The Ripple Effect Mapping work also records data sharing, place-based targeting, development of practical tools and protocols, training activity and feedback loops intended to identify gaps and support improvement.

There are examples of changes being implemented following learning, including revised mental health pathways, the Suicide Prevention Protocol, staff training and patient safety alerts. Training evidence shows that the suicide awareness module is mandated within the Mental Health and Learning Disabilities (MHLDD) Division, and that 2,244 completions were recorded between January 2023 and November 2025, with 90% of participants reporting increased confidence in asking about suicide.

Objective 3: To review how suicide prevention activity and outcomes are monitored and reported to provide assurance to the Board.	Limited
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Overview / Summary of Observations

A range of information is available to monitor suicide prevention activity. The regional action plan provides progress updates against actions, while data from the Real Time Suspected Suicide Surveillance (RTSSS) system and other reports provide data on suspected suicides, trends and

risk factors. The regional North Wales Suicide and Self-harm Prevention Regional Profile also brings together information on deprivation, priority groups, local characteristics and available services to support planning across North Wales.

There is evidence that this information is used to inform decisions. For example, concerns identified through RTSSS led to a specific review of suicide and self-harm among older people. Data and intelligence have also been used to identify priority locations and higher-risk groups. The Ripple Effect Mapping work records routine presentation of population and prevalence data and identifies Blaenau Ffestiniog, Rhyl and Wrexham as priority locations. The patient safety alert provides a further example of emerging incident information leading to safeguarding escalation, wider communication and additional reporting requirements.

There are escalation routes at regional and MHL D divisional level. The regional Forum reports to the National Programme Board, and MHL D reports provide information on inquests, Regulation 28 reports and outstanding actions. However, no single regular Health Board suicide prevention assurance report was provided that brings together progress against the regional plan, Health Board activity, risks, performance data, incidents and outstanding actions. Management advised that the first formal report against the recently adopted North Wales Multi-agency Suicide Prevention and Self-harm Action Plan 2025–2028 was due in September 2026.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 Reporting</p> <p>There is a significant amount of suicide prevention information, however it sits across different regional and internal reporting routes. The regional action plan contains progress information; mortality reports contain outcome and trend data; and MHL D reports contain incidents, inquests and Regulation 28 information. However, the evidence did not demonstrate a single Health Board report bringing these together.</p> <p>The regional Forum reports upwards to the National Suicide and Self-harm Programme Board, but the evidence provided did not demonstrate routine reporting of the overall Health Board suicide prevention position to a Health Board-level committee.</p>	<p>Senior management and the Board may not have a complete view of progress, risks, trends and outstanding actions, reducing their ability to provide effective challenge and assurance.</p>	<p>Agreed Action:</p> <p>The Health Board will implement a quarterly Suicide Prevention and Self-Harm Assurance Report to provide a consolidated overview of:</p> <ul style="list-style-type: none"> • Progress against the regional and Health Board delivery plans. • Suicide and self-harm intelligence and trend data. • Patient safety incidents, inquests, Mortality Review and Regulation 28 themes. • Risks, mitigating actions and outstanding recommendations. • Delivery milestones and performance indicators. <p>The report will be presented through the divisional Clinical Effectiveness Group and MH&LD Governance Framework, with escalation to the appropriate Executive Committees.</p> <hr/> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Approved reporting template. • Quarterly assurance report produced and submitted through governance arrangements. • Evidence of review and scrutiny by relevant committee(s). • Inclusion of risk, performance, action plan progress and learning themes within reports.

		<p>Overall accountability and assurance will be established beginning with SRO accountability, supported by a Health Board delivery plan, a consolidated assurance report and robust Board-level oversight.</p> <p>These arrangements will address the audit findings relating to governance, planning, and reporting, while providing clear evidence that the Health Board has effective mechanisms in place to demonstrate ownership, delivery, monitoring, escalation, and ongoing assurance of suicide prevention activity.</p>
	High Priority	
Theme: Reporting	Control Design	<p>Officer: SRO for Suicide Prevention and Self-Harm supported by Quality and Patient Safety Lead</p> <p>Target Implementation Date: 28 February 2027</p>

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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

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Space Utilisation

Advisory Report

2026/27

Betsi Cadwaladr University Health Board/NHS Trust



Advisory

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

BCU-2627-31

July - August 2026

September 2026

October 2026

Stuart keen, Director of Environment and Estates

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

The audit was undertaken to determine the adequacy of, and operational compliance with, established systems for the management, control and utilisation of space within the Health Board, taking account of other supporting regulatory and procedural requirements, as appropriate.

Overview

Responsibility for space management currently sits within individual Integrated Health Communities (IHCs) and the Mental Health and Learning Disabilities (MHL) Directorate, resulting in inconsistent approaches across the Health Board. The East IHC Space Utilisation Group was identified as an example of good practice, providing structured oversight of accommodation requests, vacant space, lease management, and capital projects. Similar arrangements are not consistently in place elsewhere.

The review was unable to obtain assurance that effective governance and reporting arrangements exist across the Health Board, including clear reporting to a corporate Delivery Group for organisational oversight.

While tools such as OccupEye and MICAD (software for property, space, estates, facilities, and compliance management) are being used in some NHS Wales Organisations to better understand occupancy and space usage, there is currently no consistent Health Board-wide approach to collecting, analysing, and reporting utilisation data. OccupEye findings have, in some cases, challenged assumptions that accommodation was operating at full capacity, highlighting opportunities to optimise existing space.

Overall improvements are needed to establish consistent governance, reporting, and data-driven decision-making arrangements. Strengthening these areas would support more effective estate planning, identify opportunities for rationalisation and efficiency, and ensure estate resources are used to maximum value.

Noting the advisory nature of the review, we have not provided assurance ratings or recommendations but have identified several areas for management consideration.

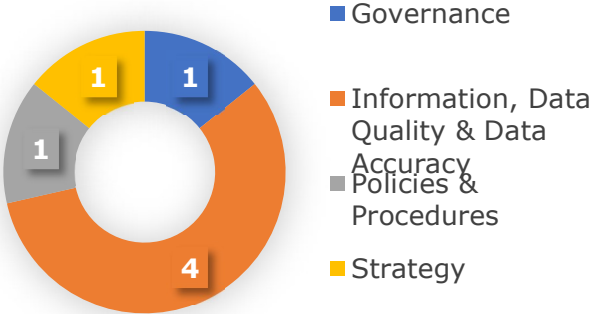
Scope & Assurance Summary

Objectives <small>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.</small>		Related Considerations
1	To obtain assurance that the Health Board has a clearly defined, approved, and effectively governed strategy for space utilisation across its estate, supported by appropriate policies and procedures. This includes assessing whether governance arrangements are robust, roles and responsibilities are clearly defined, and compliance with space allocation, usage, and optimisation requirements is consistently applied, including decisions relating to leasing, Service Level Agreement (SLAs) and surplus space.	1-3
2	To assess whether robust systems and processes are in place to establish and maintain accurate baseline data on space utilisation and associated costs, and to ensure ongoing monitoring. This includes evaluating the effectiveness of data capture methods (e.g. surveys, audits, monitoring tools), the reliability of utilisation data, and whether post-project evaluations confirm that new or refurbished spaces are used in line with business case objectives.	4-5
3	To evaluate how effectively space utilisation data is used to monitor performance against defined targets and inform strategic estate planning. This includes the extent to which insights drive decision-making, and whether appropriate actions are taken to address under-utilisation and optimise the use of space, including integration of cost considerations in planning and investment decisions.	6-7

Management Considerations

7

Themes



Risk Types

- Financial Loss
- Quality or Safety Issues
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: To obtain assurance that the Health Board has a clearly defined, approved, and effectively governed strategy for space utilisation across its estate, supported by appropriate policies and procedures. This includes assessing whether governance arrangements are robust, roles and responsibilities are clearly defined, and compliance with space allocation, usage, and optimisation requirements is consistently applied, including decisions relating to leasing, Service Level Agreement (SLAs) and surplus space.

The approved Health Board Estates Strategy (2023–2033) gives an overview of space utilisation within Section 2.4 on Estate Condition and Performance. The strategy includes the national benchmark that at least 90% of estate space should be fully utilised. As of 2021–2022, the Health Board reported utilisation at 93%, exceeding this target.

There is currently no overarching strategy, nor any up-to-date formal policies or procedures, governing space utilisation across the Health Board. Responsibility for managing space utilisation currently rests with the Integrated Health Communities (IHCs) and Mental Health and Learning Disabilities (MHLD) directorate. To understand the arrangements in place, we met with key contacts from these areas to identify the processes, guidance, and controls they use to support the effective utilisation of space.

We identified examples of good practice within the East IHC, where a dedicated Space Utilisation Group has been established. The group meets quarterly and is chaired by the Director of Operations (East), with support from the Business Manager. The group provides oversight of a range of space utilisation matters, including action tracking, new accommodation requests, a centralised register of departments requiring accommodation, vacant accommodation, capital projects, lease analysis, and other relevant issues. The group reports into the Senior Leadership Team, and evidence of Chair's reports was provided, evidencing reporting.

Overall, we were unable to obtain assurance that an effective and consistently applied governance framework for space utilisation is in place across the Health Board. The IHCs and MHLD are at varying stages in the development of their space utilisation arrangements, with matters such as accommodation requests and lease management being considered through divisional estates capital groups. East IHC has established a more mature and structured approach through its Space Utilisation Group. While other areas have begun to adopt aspects of this model, wider implementation of this good practice could help promote greater consistency, strengthen governance arrangements, and support the more effective utilisation of estate resources across the Health Board.

We have not been able to establish a reporting structure into the relevant committee/Executive Delivery Group for greater organisational oversight and assurance.

Management Consideration 1: Estates Strategy

The Estates Strategy (2023–2033) has not been subject to a recent review. As part of the planned update, the Health Board should consider the introduction of SMART space-utilisation targets and associated performance measures to facilitate effective monitoring, support accountability, and enable assessment against relevant benchmarks and metrics.

Establishing a defined timetable for completion of the Strategy, supported by appropriate governance oversight, would help ensure progress is maintained and that space utilisation remains aligned with organisational objectives and estate planning requirements.

Currently, responsibility for space utilisation rests with the Integrated Health Communities (IHCs) and individual services. Consideration should be given to transferring ownership of this function to the Operational Estates Department, as space utilisation is a Health Board-wide issue that will benefit from a strategic and consistent approach.

Centralising responsibility within Operational Estates could support greater oversight, improved standardisation of processes, and more effective management of estate resources across the organisation

Management Response:

The core consideration is accepted as identifying areas to address in maximising space utilisation and the corporate ownership of the estate.

The Health Board has commenced actions which will lead to the review and updating of the 2023-2033 Estate Strategy but the timeline will be linked to the updating of the Clinical Strategies and Plans and Estates is seen as an enabler. The process has started under the Interim Executive Director Transformation and Strategic Planning. In updating the Estate Strategy, a key part is understanding the current estate which includes utilisation and use and that data need collating and most importantly validating.

The corporate ownership of space is currently, as noted in the audit, vested in the IHC's and the Foundations for the Future Programme may have revised that. Notwithstanding that, the responsibility for the management of space should be clarified at a corporate level. If vested in the IHC, a formal Space Utilisation Policy and Procedure should be developed.

Target Implementation Date:

Collation and validation of current space utilisation – by end of Q4 2026/27.

Confirmation of corporate ownership of space – by end of Q3 2026/27.

Development of Space Utilisation Policy – by end of Q2 2027/28.

Management Consideration 2: Space Utilisation Policy / Procedures

The Health Board does not currently have an up-to-date policy or procedure that sets out its approach to space utilisation management.

Management may wish to consider developing a proportionate space utilisation policy / procedure, which could bring together strategic principles, utilisation targets, governance responsibilities and reporting arrangements, to support a consistent and transparent approach to managing estate capacity.

Management Response:

The management consideration is agreed and considered above within MC1 above.

Target Implementation Date:

Refer to MC1 above.

Management Consideration 3: Governance and Accountability

The Health Board would benefit from strengthening its governance arrangements for space utilisation by establishing a formal reporting structure whereby local Space Utilisation group(s) report into a Health Board wide group e.g. Capital Investment Group and for assurance into the relevant Executive Delivery Group.

This would provide greater organisational oversight and assurance regarding the effective management and utilisation of estate resources across the Health Board, while supporting a more consistent and strategic approach to accommodation planning and decision-making.

The good practice observed within the East IHC demonstrates the benefits of having a structured and proactive approach to space utilisation. The establishment of a dedicated Space Utilisation Group has provided a forum for reviewing accommodation needs, monitoring vacant space, overseeing capital projects, and coordinating accommodation requests, supported by clear reporting arrangements to senior management. Consideration should be given to adopting a similar model across the remaining IHCs and service areas within the Health Board. A consistent approach would help strengthen governance, improve the sharing of information and best practice, and support more effective and strategic utilisation of estate resources across the organisation.

Management Response:

The management consideration is agreed and considered above within MC1 above.

Target Implementation Date:

Refer to MC1 above.

Objective 2: To assess whether robust systems and processes are in place to establish and maintain accurate baseline data on space utilisation and associated costs, and to ensure ongoing monitoring. This includes evaluating the effectiveness of data capture methods (e.g. surveys, audits, monitoring tools), the reliability of utilisation data, and whether post-project evaluations confirm that new or refurbished spaces are used in line with business case objectives.

The current Estates Strategy presented basic baseline metrics of space utilisation and functional suitability. A snapshot of performance using the Estates Strategy baseline and most recent Estates & Facilities Performance Management System (EFPMS) data, shows the following:

Year	2021-22 (Estates Strategy)	2024/25 (EFPMS)	Trend
Space Utilisation	93%	95%	+2.1%
Functional Suitability	74%	80%	+8.11%

The lack of comprehensive space utilisation data across the NHS Wales estate presents a challenge to effective estate planning and decision-making. The Estates MICAD system, which contains floor plans, computer aided design (CAD) drawings and associated estate information, could be utilised more effectively to identify the location of staff and teams across the Health Board. This would enable the development of a more comprehensive baseline dataset relating to space occupancy and utilisation,

To further support this issue, Welsh Government commissioned NWSSP Specialist Estates Services (SES) to support NHS Wales organisations in collecting reliable and meaningful utilisation data through the deployment of the OccupEye monitoring system. The sensors deployed collect anonymous data on desk and room usage to inform managers when and where space is most effectively used.

OccupEye reports from areas were provided as evidence to support requests for additional clinical rooms. Communications between some departments indicated that available space was fully utilised and that room schedules were operating at full capacity; the findings from the OccupEye reports did not consistently support these assertions.

OccupEye is expected to provide the Health Board with a more accurate assessment of space utilisation by collecting continuous, real-time occupancy data rather than relying on manual surveys. As the system is deployed across additional sites and data is gathered over a longer period, it will generate a comprehensive picture on how rooms and clinical spaces are actually used (in line with business case objectives), including patterns of occupancy, peak usage periods, and areas of underutilisation. This improved evidence base will enable the Health Board to make more informed decisions regarding estate planning, service delivery, and space optimisation, ensuring that available accommodation is used as efficiently and effectively as possible.

Management Consideration 4: Centralised Data Repository

As the Health Board’s access to estate data continues to improve through the development of arrangements throughout the areas, consideration could be given to establishing a centralised repository of key estate information. Bringing together data such as floor area measurements, occupancy levels, space utilisation, lease agreements, and associated costs would support more informed planning, improved oversight, and enhanced decision-making.

Consideration should be given to maximising the use of the Estates MICAD system to record and monitor staff and team locations. By utilising the information held within the system, the Health Board could establish detailed and reliable baseline metrics for space utilisation, supporting strategic estate planning, capacity management and the identification of opportunities to optimise the use of available accommodation.

Management Response:

The management consideration is accepted – an estate management platform has the potential to improve efficiency and visibility provided the input data is correct. At present, the 95% Space Utilisation data from EFPMS should be validated because the use of OccupEye suggests about half that is realistic in places. Work has already commenced on the selection and procurement of a CAFM system and optional ‘bolt-on’ modules for space utilisation. This is subject to procurement and finance approvals.

Target Implementation Date:

Implementation of CAFM – by Q4 2026/27.

Review of Space Utilisation module – by Q2 2027/28.

Management Consideration 5: OccupEye

NWSSP: Specialist Estates Services provides a free service to NHS Wales organisations in the application of the OccupEye equipment and software, and reporting of data obtained, to support opportunities to identify, plan and deliver improved space utilisation.

Evidence was provided demonstrating the use of OccupEye on projects within the East and West areas. We noted that one project identified overall average utilisation across the survey period as being below expected levels, while another highlighted specific rooms where utilisation could be further optimised.

The Health Board may therefore benefit from consideration of wider application of this free service to inform its future planning of estate rationalisation and future capital investment proposals.

Management Response:

The management consideration is accepted, but it should be noted that the size of the BCUHB estate is such that the use of OccupEye in all areas will take time and would benefit from focus based upon targeted estate rationalisation priorities.

Target Implementation Date:

To align with the development of the estate strategy and MC4 (space utilisation module).

Objective 3: To evaluate how effectively space utilisation data is used to monitor performance against defined targets and inform strategic estate planning. This includes the extent to which insights drive decision-making, and whether appropriate actions are taken to address under-utilisation and optimise the use of space, including integration of cost considerations in planning and investment decisions.

The review found evidence of local initiatives to improve understanding of space utilisation, including the use of OccupEye surveys to measure occupancy levels and identify opportunities to make better use of estate assets. Survey findings have been used to highlight areas of under-utilisation and accommodation with capacity for increased use.

However, there is currently no consistent Health Board-wide approach to the collection, analysis and reporting of space utilisation data. While good practice was identified within the IHC East area, where space management information supports accommodation planning, vacant space monitoring, capital projects and lease management, similar arrangements were not consistently evident across the organisation.

The absence of comprehensive and routinely collected utilisation data limits the Health Board's ability to monitor performance, assess trends, measure achievement against utilisation targets and demonstrate that estate decisions are evidence based. Consequently, opportunities to address under-utilisation, rationalise the estate and maximise value from existing accommodation may not be identified or pursued systematically. In addition, there was limited evidence that space utilisation information is routinely linked with financial and cost data to inform investment and estate management decisions.

Management Consideration 6: Accommodation Request System

Although the IHC East area maintains a robust and comprehensive Schedule of Master Forms and Documents, the Health Board does not currently have a readily accessible central record of accommodation requests and approvals. To strengthen arrangements further, consideration should be given to implementing a standardised electronic accommodation request system, enabling services to submit requests more efficiently, ensuring appropriate approvals are captured, and providing a centralised audit trail of all accommodation-related activity.

Management Response:

Management consideration accepted and this can be part of a Space Utilisation Procedure and Policy addressed in management consideration 1.

Target Implementation Date:

To align with the development of the Space Utilisation Procedure and Policy at MC1.

Management Consideration 7: Enhancing Space Utilisation Insights to Support Decision

The Health Board should consider implementing regular reporting on key space utilisation metrics and related activity to relevant governance groups and Committees, including the incorporation of performance measures within the Estates Strategy. This would enhance oversight of estate utilisation, support data-driven decision-making, and facilitate the timely identification of opportunities to optimise, rationalise, or reconfigure accommodation assets.

Management Response:

Management consideration accepted and this can be part of a Space Utilisation Procedure and Policy addressed in management consideration 1.

Target Implementation Date:

To align with the development of the Space Utilisation Procedure and Policy at MC1.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

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

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