Bundle BCU Audit Committee 18 August 2026

To support item AC26.85 Internal Audit Progress report
1. Purchase Cards & Petty Cash (BCU-2526-42) 2. Budget Setting (BCU-2526-09) 3. Sickness Management – Corporate Directorates (BCU-2526-41) (2026/27) 4. To be discussed at Agenda item AC26.88 5. Urgent and Emergency Care: Implementation of Audit Wales actions (BCU-2526-20) 6. Capital Governance Arrangements (BCU-SSU-2526-43) 7. Speaking Up Safely (BCU-2526-25) 8. Planned Care Major Change Programme – Governance and Delivery (BCU-2526-19) 9. Executive Committee: Governance (BCU-2526-05) 10. Non-DDaT controlled IT (BCU-2526-16) 11. Standards of Business Conduct (BCU-2526-04) 12. Pharmacy Regulatory Requirements (BCU-2526-40) 13. Challenged services – Improvement plans (BCU-2526-30) 14. Nuclear Medicine Consolidation Project (BCU-SSU-2526-45)

1. BCU-2526-42 Final Internal Audit Report_Purchase cards and Petty Cash
2. BCU-2526_09 Final Internal Audit Report Budget Setting for client issue
3. BCU-2526-41 Final Internal Audit Report Sickness Management (1)
5. BCU-2526-20 Internal Audit Report - UEC Implementation of Audit Wales actions
6.BCU-SSU-2526-26 Capital Governance Arrangements _ Final Advisory Report
7. BCU-2526-25 Final Internal Audit Report_Speaking Up Safely_for client issue
8. BCU_2526_19 Final Internal Audit Report Planned Care Major Change Programme
9. BCU-2526-05 Final Internal Audit Report - Executive Committe Governance
10. BCU-2526-16 non ddat IT final internal audit report
11. BCU-2526-04 Final Internal Audit Report - SOBC
12. BCU_2526_40 Final Internal Audit Report Pharmacy Regulatory Compliance
13. Final Internal Audit Report - Challenged Services - Improvement plans
14. BCU-SSU-2526-45 Final Internal Audit Report Nuclear Medicine

Purchase cards and Petty Cash

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2526-42
Fieldwork	February - March 2026
Executive Sign Off	4 May 2026
Audit Committee	June 2026
Executive Lead	Russell Caldicott, Executive Director of Finance
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Ossama Lotfy, Principal Auditor

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To assess the Health Board's compliance with financial procedures F07 (Petty Cash) and F08 (Purchasing Card).

Overview

Overall, the Health Board is compliant with Financial Procedures F07 (Petty Cash) and F08 (Purchasing Card). The controls in place are generally robust and operating effectively, with no significant weaknesses identified.

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

- Training for imprest holders and cardholders is provided on an ad hoc basis. There is no formal training programme, no requirement for periodic refresher training, and no central record of training completion.
- At some locations visited, key security and access controls to the safe require review to ensure the safe custody of Health Board monies at all times.
- Per procedure, there is no documented evidence to demonstrate that monthly independent checks of sub-imprest floats are consistently carried out.

Management Issue: During our review, we found one cardholder agreement missing from our sample. We were informed that this instance occurred before the current process requiring signed agreements. Although we have not identified this as a risk issue, management should make sure that all cardholders who received purchase cards before the agreement was implemented complete an agreement.

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

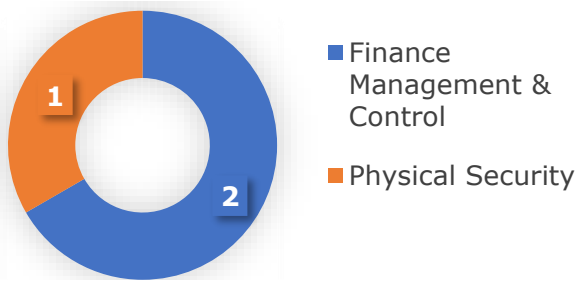
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Purchase cards and petty cash processes are operated in accordance with BCUHB policies and SFIs.	1	**Reasonable**
2	Expenditure is legitimate, properly authorised, and supported by adequate documentation.	2 & 3	**Reasonable**
3	Financial records are accurate, reconciled, and subject to regular review.	-	**Substantial**

Management Actions

0	3
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Purchase cards and petty cash processes are operated in accordance with BCUHB policies and SFIs.	**Reasonable**

The Health Board has established formal financial procedures for both petty cash (F07) and purchase cards (F08), aligned with the Standing Financial Instructions and Standing Orders. These procedures set out responsibilities, authorisation requirements, permitted expenditure categories, and the processes for reconciliation and monitoring. Receipt retention requirements for both systems are detailed within the Corporate Records Management Procedure IG02, Appendix C.

For petty cash, the approved expenditure categories are outlined in Section 9 of Financial Procedure F07, which also specifies reconciliation and monitoring actions supported by control pack checklists. Training for imprest holders is provided by the Assistant Accountant – Treasury and Control on an as-required basis, typically for new holders or following specific queries, and is delivered either via Microsoft Teams or in person. Additional guidance has been circulated by the Local Counter Fraud Service through the weekly corporate bulletin. The petty cash procedure was updated in 2025, with the next review scheduled for 2027, and copies are available on the intranet (Betsinet) and referenced in weekly staff bulletins.

For purchase cards, Financial Procedure F08 outlines responsibilities, authorisation levels and reconciliation requirements, with purchasing categories set individually based on service needs. Training is provided by the Assistant Accountant – Treasury and Cash Management as required, using online or in-person delivery. Procedure F08 was updated in 2025 and is due for review in 2027, with accessible copies also available on Betsinet and highlighted in corporate communications.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Training for Imprest and Card Holders** Training for imprest holders (Financial Procedure F07) and card holders (Financial Procedure F08) is delivered on an as-required basis, typically when a new staff member assumes the role or when a specific request for guidance is made. There is no formal training schedule, no requirement for periodic refresher training, and no central record of completion. This results in inconsistent levels of knowledge among holders, particularly for long-standing staff or those who received informal training.	Imprest holders or card holders may apply financial procedures incorrectly, increasing the risk of: • Errors in petty cash and card transactions. • Non-compliance with Financial Procedures F07 and F08. • Inaccurate reconciliations or delays in	**Agreed Actions:** A training schedule will be prepared by the Finance Department with an initial rolling training programme to be completed during 2026. A record of all staff members who have received training, either for the first time, or refresher training, will be retained centrally by the Finance Department. **Expected Evidence of Implementation:** • Scheduled refresher training or when procedures change or issues identified. • Central recording of training attendance within Finance.

		resolving variances.	
		Medium Priority	**Officer**: Head of Financial Control and Assistant Accountant, Treasury and Control
	Theme: Finance Management & Control	Control Operation	**Target Implementation Date**: 31 October 2026

Objective 2: Expenditure is legitimate, properly authorised, and supported by adequate documentation. **Reasonable**

Purchase Cards

We reviewed purchase card controls across the period December 2024 to November 2025. Management provided a list of cardholders, including individual spending limits and appropriate purchasing categories aligned to roles within the Health Board.

A sample of five cardholders was selected to confirm that signed cardholder agreements were in place. Evidence was available for four individuals; however, no signed agreement or retained approval evidence could be provided for one cardholder. Finance advised that the agreement dated back to 2014 and would have been approved via email, but this record is no longer available due to retention limitations and staff changes. There is a risk that purchasing cards may be issued without appropriate authorisation and that the organisation cannot demonstrate adequate oversight or compliance with internal control requirements.

A further sample of 17 transactions was tested to confirm compliance with procedures. This included review of purchase card logs, receipts, and invoices, as well as evidence of appropriate approval. All transactions tested were fully supported, appropriate, and in line with established procedures.

Overall, controls are operating effectively, with one minor documentation exception identified.

Petty Cash

We reviewed petty cash arrangements across a sample of locations within the Health Board. A list of imprest holders was obtained, and management confirmed that holders are locally appointed and provided with the relevant financial procedures. Annual imprest balance confirmations are also required.

Testing was undertaken at five sites: Wrexham Maelor Hospital, Ysbyty Glan Clwyd, Ysbyty Gwynedd, Ty Llywelyn and Ruthin Hospital. While overall processes for petty cash management and top-up arrangements were found to be operating effectively, some control weaknesses were identified during site visits.

Inadequate key security arrangements, such as the absence of duplicate keys, unrestricted access to spare keys, and keys being taken off-site due to a lack of secure storage. In addition, there was no evidence of monthly independent checks of sub-imprest floats, as required by procedure.

Testing of petty cash top-ups for January and February 2026 confirmed that reimbursement forms were appropriately completed, authorised, and accurately recorded in Oracle, with no discrepancies identified against records from the secure cash in transit provider.

A small number of transactions exceeding the £40 limit were identified; however, these are subject to Finance review and approval in exceptional circumstances as detailed in the procedure.

Key Findings		Risk & Impact	Agreed Management Action
2	**Inadequate Key Security and Access Controls** • At Wrexham Maelor Hospital and Ruthin, only one key exists for the petty cash safe, contrary to Section 7 of the Petty Cash Financial Procedure requiring a duplicate key held separately. • At Ysbyty Gwynedd, the duplicate key is taken off-site by staff due to absence of a secure key safe. • At Ty Llywelyn, access to the duplicate key is not restricted, as it is stored in a shared lock box accessible to administrative staff, multiple staff (beyond authorised personnel) could potentially access the petty cash safe key due to shared storage arrangements.	• Increased risk of loss of access if the key is misplaced • Weak business continuity arrangements • Increased risk of unauthorised access to petty cash • Non-compliance with financial procedures	**Agreed Action:** All petty cash imprest holders will be contacted to ensure that they are able to comply with Section 7 of the petty cash financial procedure and alternative arrangements/additional security measures will be put in place where they advise that this is not currently possible. Key security and access controls will also be covered as part of the training programme in Key Finding 1 above. **Expected Evidence of Implementation:** • Management ensure compliance with Section 7, including requirements for duplicate keys and secure storage. • Key register / logbook documenting key holders, access, and periodic checks. • Only authorised staff access petty cash keys (e.g. restricted key safe codes or named individuals).
		Medium Priority	**Officer:** Head of Financial Control and Assistant Accountant, Treasury and Control **Target Implementation Date:** 30 June 2026
	Theme: Physical Security	Control Operation	
3	**Lack of Evidence of Monthly Sub-Imprest Checks** Across all sites, there was no evidence of monthly checks of sub-imprest floats by main petty cash holders as required by procedure.	• Errors or discrepancies may go undetected • Increased risk of financial loss or irregularities • Non-compliance with internal financial controls.	**Agreed Action:** Sub-imprest checks are required within Financial Procedure F07 – Petty Cash. A new sign-off sheet will be introduced at the main sites that hold petty cash sub-imprests so that the monthly checks of these balances is evidenced and submitted to the Finance Department. **Expected Evidence of Implementation:** • Completed monthly check records/sign-off sheets by main cash holders with Finance management oversight evidence.
		Medium Priority	**Officer:** Head of Financial Control and Assistant Accountant, Treasury and Control **Target Implementation Date:** 31 July 2026
	Theme: Finance Management & Control	Control Operation	

Objective 3: Financial records are accurate, reconciled, and subject to regular review.	**Substantial**

The review of petty cash and purchase card controls indicates that key reconciliation processes are operating effectively, with appropriate segregation of duties and timely completion in line with the Financial Services Monthly Control Pack Checklist.

Petty cash reconciliations are performed by a Senior Financial Services Officer and independently reviewed by either the Assistant Accountant for Cash and Treasury Management or the Head of Financial Control. Testing of reconciliations for the period August to November 2025 confirmed that balances were accurate, properly authorised, and supported by appropriate documentation. One discrepancy of £17.95 relating to Glan Clwyd Hospital was identified during testing; however, this was subsequently explained by management as a vending machine float adjustment following the withdrawal of a machine.

Purchase card reconciliations are also completed in a timely manner and subject to appropriate review. Testing across the same period confirmed that control account balances were consistently reconciled to the general ledger, with no discrepancies noted. All reconciliations were appropriately authorised and evidenced.

Both petty cash and purchase card activity are monitored on an exception basis, with any significant issues reported to the Audit Committee. No exceptions or breaches requiring escalation were identified during the review period. Management further advised that no issues have been identified in recent months that would necessitate reporting or escalation to senior management or the Audit Committee.

Overall, controls in these areas are considered robust and operating effectively, with no significant weaknesses identified.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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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 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.

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

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Budget Setting

Internal Audit Report
2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2526-09
Fieldwork	December - March 2026
Executive Sign Off	14 May 2026
Audit Committee	June 2026
Executive Lead	Russell Caldicott, Executive Director of Finance
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit Laura Howells, Internal Audit Manager

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Audit and Assurance Services

Executive Summary

Purpose

The Health Board IMTP for 2025-26 states 'The 2025/26 financial plan aligns with the strategic ambition of the Health Board in attaining the key financial duty to break even, laying the foundations that will enable attainment of a productive, efficient and employed workforce offering high quality patient care that is financially sustainable. Expenditure commitments will need to be prioritised to enable the key financial duty and the performance ask to be attained'.

The review set out to assess how the Health Board allocates resources to meet its agreed budget.

Overview

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

- The Health Board's financial plan is heavily reliant on delivery of planned savings in order to achieve a balanced position.
- There is not a clearly consistent approach across divisions to determine when a formal financial recovery plan should be triggered for materially overspent areas.
- The accountability agreement process has not been fully completed, as not all budget holders have signed and returned their accountability letters.

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

It is noted that the Health Board has not undertaken zero-based budgeting in recent years. However, with the Foundations for the Future programme progressing, this provides an opportunity to strengthen the budget setting approach, including the potential adoption of zero-based budgeting principles. This represents an opportunity for enhancement and does not impact the overall opinion.

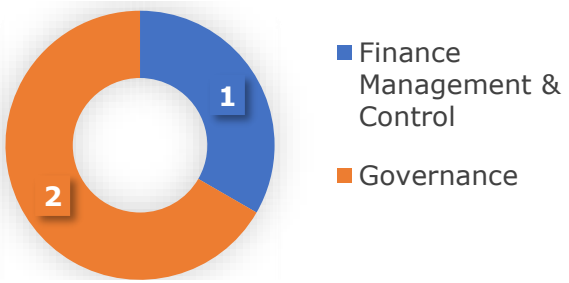
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The health board has an appropriate financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements.	1	**Limited**
2	There is clear and robust challenge of the Financial Plan, its assumptions, and associated risks by senior management, the Board and its committees, and Welsh Government.	-	**Reasonable**
3	Budget holders are actively engaged at an early stage and supported throughout the budget setting process, and the health board has sufficient internal resources, skills and systems to enable effective budget planning.	-	**Substantial**
4	Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up-to-date policies and procedures.	2	**Reasonable**
5	Effective processes are in place within the Service Groups in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.	3	**Reasonable**

Management Actions

1	2
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Findings & Agreed Action Plan

Objective 1: The health board has an appropriate financial planning approach that aligns the key organisational priorities, available resources and Welsh Government's requirements.	**Limited**

Overview / Summary of Observations

The Health Board had a structured budget-setting and financial planning approach in place for 2025/26. The process was supported by a formal planning timetable (for the integrated plan), milestone meetings, planning huddles, financial planning principles, budget setting notes and Welsh Government template guidance. The Board formally considered the financial plan before submission, and the annual budget was clearly linked to the first year of the Integrated Medium Term Plan (IMTP) in line with the Health Board's budgetary control procedure.

The budget-setting calculation provides a clear audit trail showing how the Health Board moved through recurrent and non-recurrent funding adjustments, return of top-sliced funding, savings targets, specific Welsh Government allocations and financial plan adjustments. At overall Health Board level, the calculation shows an initial income and expenditure gap of £8.611m, offset by a £40.0m savings target, £6.051m of specific Welsh Government allocations and £25.337m of financial plan adjustments, resulting in a balanced opening position. Central reserves also remained a significant part of the framework, including £62.254m of financial plan funding at the start of the financial year.

While the planning framework was clear and documented, the financial plan remained challenging. The Health Board's IMTP was submitted on time but was not approved by Welsh Government, which later imposed accountability conditions. Welsh Government did not approve the IMTP because it was judged not to meet the wider NHS Wales Planning Framework requirements on deliverability, milestones, risks and performance expectations, rather than for budget submission alone. This indicates that, although the planning process itself was structured and timely, the deliverability of the plan remained subject to external concern. Overall, the Health Board demonstrated a defined and controlled planning approach, but one operating in a highly constrained financial environment.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Budget Deficit - savings** The Health Board's opening financial position was heavily reliant on savings and central adjustments to balance the budget. The budget-setting calculation shows an initial income and expenditure gap of £8.611m, a £40.0m savings requirement, and significant use of central reserves, including £62.254m of financial plan funding at the start of the year. This pressure was evident early in-year, with a £3.7m start of financial year deficit, of which £2.7m related to unachieved savings. Together, this indicates a risk that the financial plan may not be delivered if savings are not achieved and underlying pressures continue.	There is a risk that: If the Health Board does not deliver the required savings, or if further financial pressures arise that are not offset by mitigating action, the financial plan will not be delivered, and the planned balanced	**Agreed Action:** Divisional savings targets are established prior to the commencement of the financial year and communicated to Divisional Directors accordingly. Delivery of these savings is monitored on a monthly basis against the agreed plan, performance reported and scrutinised through a range of governance forums, including IPEDG, Value & Sustainability Board, Finance Oversight Group, PFIG, and the Health Board. Savings delivery is also one of the key metrics to be reviewed as part of the Accountability Framework. Monthly reports are prepared by Finance Leads at a divisional level and presented to the respective Senior Leadership Teams, with presentation at the Operational Leadership Forum the

		position will not be sustained.	importance of identifying opportunities for savings delivery early for the next financial year. To support the timely development and agreement of savings plans, divisional savings targets will be issued earlier in the financial year, enabling a greater proportion of plans to be developed in advance of commencement of the financial year.
			Expected Evidence of Implementation: Indicative savings targets to be issued in October for the next financial year, savings plans requiring development throughout the financial year and for the next financial year in advance of commencement of the new financial year. Continued reporting of savings performance through Value & Sustainability for the current and future years, this a key measure of delivery under the new Performance and Accountability Framework for areas and directorates and used to assess delivery within their performance reviews. Performance reported monthly on savings delivery within the governance forums articulated within the management response.
		High Priority	**Officer:** Executive Director of Finance **Target Implementation Date:** 31 March 2027
	Theme: Finance Management & Control	Control Design	

Objective 2: There is clear and robust challenge of the Financial Plan, its assumptions, and associated risks by senior management, the Board and its committees, and Welsh Government.	**Reasonable**

Overview / Summary of Observations

Health Board minutes evidence challenge to the financial plan, assumptions and risks. The planning timetable and critical milestone schedule show that the plan was developed through a series of formal checkpoints, including Executive Team review, Performance, Finance and Information Governance Committee review and Board approval. Regular planning huddles were held bi-weekly at key times of the year, which included staff from across the Health Board including, but not limited to, Planning, Finance, Corporate and Transformation and Improvement. This provides additional assurance that challenge and review took place throughout the planning process rather than only at year end. We are advised there were regular discussions with Financial Planning and Delivery Unit, within NHS Wales Performance and Improvement, about the plan.

Financial planning assumptions were set out in a formal document and financial planning principles were discussed through the pan Wales Deputy Directors of Finance Forum to support consistency across Wales where possible.

There was also evidence of challenge and monitoring in-year. For Women's Services, local governance papers showed active discussion of the overspend position, savings shortfall and required actions. For Mental Health and Learning Disabilities, the Month 10 finance report identified a £15.36m year-to-date overspend and a forecast year-end overspend of £18.37m, with particular focus on out-of-area placements, Continuing Health Care, staffing and medical pay. See objective 4 for more information.

Overall, the evidence supports that the financial plan and its risks were subject to challenge at corporate, divisional and external level. The main weakness was not lack of scrutiny, but the scale of the financial challenge being managed.

Objective 3: Budget holders are actively engaged at an early stage and supported throughout the budget setting process, and the health board has sufficient internal resources, skills and systems to enable effective budget planning.	**Substantial**

Overview / Summary of Observations

Budget holders and divisional management teams were engaged in the budget-setting process and subsequent financial monitoring. Local finance and operational papers in both Divisions chosen for further testing (Women's Services and Mental Health and Learning Disabilities (MH&LD)) show that opening budgets, savings requirements, pressures and actions were discussed through formal directorate structures. For Women's Services, this included the Budget and Savings, Senior Leadership Team and Service Board meetings. For MH&LD, the divisional budget allocation paper was presented to Divisional Senior Leadership Team (DSLT) and followed by area accountability meetings reviewing finance, savings and workforce controls. This demonstrates that local teams and operational leaders were involved in translating the Health Board budget into service-level budgets and actions.

System and delegation controls were also evidenced to a sufficient level. The Scheme of Reservation and Delegation (SoRD), local delegation arrangements and system-derived delegated limits support that delegated financial authority is set within a formal framework and reflected in live systems. Core systems, dashboards and tools are used to support budget management, including Oracle, local spreadsheets, budget reporting and divisional finance reports. Overall, there is sufficient evidence that budget holders were engaged and supported and that the Health Board has the systems and tools necessary to operate the budget-setting process.

Objective 4: Roles, responsibilities and the arrangements for budget setting are clearly set out within the Accountability Letter and up-to-date policies and procedures.	**Reasonable**

Overview / Summary of Observations

The Health Board has a clearly documented framework setting out roles, responsibilities and budgetary accountability. The Standing Financial Instructions include the responsibility of the Executive Director of Finance in relation to budget setting, supported by the Procedure on Budgetary Control which defines the responsibilities of the Board, Chief Executive, Executive Director of Finance, finance teams and budget managers. It states that budget managers must operate within delegated limits, review monthly reports, agree accountability arrangements and develop recovery plans where overspends arise. The Budgetary Control procedure includes but not limited to:

- Roles and responsibilities;
- Delegation and Accountability;
- Changes to the budget;
- Performance Management; and
- Budgetary Control and Responsibility.

This is supported by the Budget Manager Handbook, the local Standard Operating Procedure on budgetary movements and the Scheme of Reservation and Delegation of Powers, which together provide a framework for budget setting, delegation and budget management.

The Accountability Agreement template is detailed and clearly sets out the expectations placed on budget holders, including responsibility for managing delegated budgets, complying with Standing Orders, Standing Financial Instructions and the Scheme of Delegation, identifying savings opportunities, and ensuring onward delegation is only made to appropriately authorised staff. This demonstrates that the Health Board has a formal mechanism for setting out financial accountability to budget holders.

However, while the accountability framework is well designed, it was not fully completed in practice. Management confirmed that 11 out of 433 accountability agreements had received no response, including at senior Director level. This means that, although accountability agreements were issued widely across the organisation, formal acceptance of delegated financial responsibility was not consistently evidenced across all relevant postholders. This weakens assurance that all budget holders had formally acknowledged their delegated responsibilities by the required point in the year. However, the number of staff who have not signed their accountability letters has reduced from previous years which is positive to note.

Overall, the Health Board had a strong policy and procedural framework for budget accountability, but there is scope to strengthen follow-up and escalation where accountability agreements are not returned or acknowledged.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Accountability Agreements** The Health Board had a formal accountability agreement process in place, supported by a standard accountability letter	There is a risk that: If accountability agreements are not	**Agreed Action:** Accountability letters for 2026/27 were issued on 8 May 2026 and included an attachment detailing the opening budgets under the

	and a central reporting mechanism. However, the process was not fully completed in practice, as 11 accountability agreements had received no response, including at senior Director level. This means that, while the framework for budget accountability was clearly defined, it was not fully evidenced as operating consistently across all budget holders. However, the position has improved from previous years.	acknowledged or returned, there is a risk that budget holder responsibilities are not formally accepted and that lines of financial accountability are weakened, particularly in areas with significant delegated budgets.	responsibility of each budget holder. Finance Leads will also meet with all budget holders before the end of May to review and discuss their allocated budgets. Targets for Accountability Agreement sign-off are set within the IMTP, with delivery monitored through the Annual Delivery Plan. The target is for 95% of agreements to be signed off by the end of Quarter 3. Instances of non-compliance are escalated through line management channels and, where necessary, to the Chief Executive. This process was applied for those who did not complete sign-off in 2025/26 and forms part of the escalation procedure detailed in the Performance Accountability Framework (Section 5.1). We will ensure that the escalation route is incorporated into Accountability Agreements for 2027/28.
			Expected Evidence of Implementation: All accountability letters issued at time of writing this management response to be signed by budget holders, with non-compliance escalated via performance management routes.
		Medium Priority	**Officer:** Finance Director - Commissioning & Strategy **Target Implementation Date:** 31 December 2026
	Theme: Governance	Control Operation	

Objective 5: Effective processes are in place within the Service Groups in the setting, delegation, amendment and approval of budgets, ensuring transparency and accountability.	**Reasonable**

Overview / Summary of Observations

The sample testing of Women's Services and Mental Health and Learning Disabilities showed that local budget-setting and budget management arrangements were operating in line with procedures. In both sampled areas, opening budgets were clearly derived from the Health Board's central budget-setting process and then discussed within their Divisional meetings. Women's Services had a revised opening budget of £48.942m at the start of the financial year and a budget of £47.704m after savings and adjustments. MHLD had a budget of £171.587m after funding adjustments, Welsh Government allocations and savings adjustments. Accountability agreements were signed for both areas.

There was also evidence that significant variances were identified and challenged. For Women's Services, the forecast deficit at the start of the financial year was £2.936m, with challenge and discussion through SLT and Service Board. For MHLD, the Division was £15.36m overspent year to date at Month 10 and had a formal spend reduction response, including a 1.5% spend reduction target of £2.9m and a detailed action proforma. This recovery plan was put in place for MHL&D and not Women's Services because the financial position in MHLD was worse but there does not appear to be a formal cut off or criteria for when a Division's positions become poor enough to trigger a formal recovery plan.

Mid-year amendments were clearly permitted and controlled through the Health Board's virement process, with policy guidance in place and sample virements evidencing rationale and approval. Approval arrangements for original budgets were also evidenced through directorate meetings and local budget papers. Overall, the sampled testing supports that service group budget processes were defined, delegated, monitored and subject to challenge, with the main variation being the formality of recovery planning between sampled areas.

Key Findings		Risk & Impact	Agreed Management Action
3	**Recovery plans** Both sampled divisions were actively managing overspends, but the approach was more formal and clearly documented in MH&LD than in Women's Services. Women's Services was forecasting a £2.936m overspend at the start of the financial year, including a £1.2m savings target still to be identified in full, with only £6k of schemes identified at that stage. While challenge and actions were evident through SLT and Service Board, this was less clearly set out as a formal recovery plan. In contrast, MH&LD had a more structured response; at Month 10 it was £15.36m overspent year to date and forecasting an £18.37m overspend, and had been set a £2.9m spend reduction target over the remaining five months, supported by a documented action plan.	There is a risk that: Where recovery actions are not set out in a consistent and formal way, there is a risk that financial recovery activity is harder to track, monitor and hold to account, particularly in areas already carrying significant forecast deficits.	**Agreed Action:** A standardised approach to the development of formal recovery plans will be established, with clear alignment to the Performance Delivery Framework, which defines the criteria and process for escalation. This approach will be informed by best practice and designed to ensure consistency in application across the organisation. Overall performance will be reported and continued to be managed through Executive, Integrated Performance – Executive Delivery Group and the Performance reviews for areas and directorates to commence during the current financial year. **Expected Evidence of Implementation:** Defined criteria for the implementation of formal recovery plans where there is overspend. Escalation through the governance forums referenced within the management response.
		Medium Priority	**Officer:** Chief Finance Manager: Strategy & Planning Accountant **Target Implementation Date:** 30 September 2026
	Theme: Governance	Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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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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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.

Website:

Sickness Management – Corporate Directorates

Internal Audit Report

2026/27

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2526-41
Fieldwork	May - June 2026
Executive Sign Off	22 July 2026
Audit Committee	August 2026
Executive Lead	Debbie Eyitayo, Executive Director of People Services & OD
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review compliance with the NHS Wales Managing Attendance at Work Policy, with a focus on corporate directorates within the Health Board.

Overview

The NHS Wales Managing Attendance at Work policy sets out the standards and processes that Health Boards are expected to follow to support staff wellbeing, reduce avoidable absence, and promote consistent, fair management practices.

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

- Managing Attendance at Work (MAAW) training is not mandatory and whilst training is offered, there has been poor uptake. Response to our questionnaire from corporate directorate line managers noted many had not received training; there is an opportunity for People & OD to reset the training offer ensuring line managers are sighted on their expectations to ensure Policy compliance.
- Line manager feedback confirmed a good understanding of Occupational Health (OH) referral requirements, however the reports received were not always deemed of benefit.

Full details of matters arising are detailed within the Findings and Agreed Action Plan. We have not raised findings relating to the following:

- Minor delay in completing meetings or documentation and one case where a formal return-to-work record had not been completed.
- People & OD Business Partners provide reports to corporate directorates but are not always invited to attend some Directorate Senior Leadership Team meetings to present the reports and highlight areas for management attention.

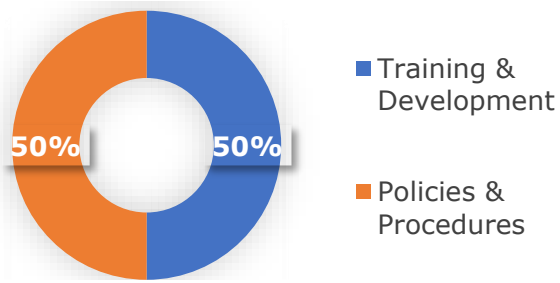
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Managers and departments are complying with the procedural requirements of the All Wales Policy. This includes timely recording of sickness, completion of required documentation, appropriate correspondence issued for sickness meetings.	-	**Reasonable**
2	Where there has been referral to Occupational Health, appropriate support is available to managers and staff, and the service has been effective in reducing absence.	1	**Reasonable**
3	Appropriate training is made available to all managers who have a responsibility for managing staff.	2	**Reasonable**
4	Adequate reporting mechanisms are in place to monitor and manage attendance levels, both locally and at Board level.	-	**Reasonable**

Management Actions

0	2
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

At a glance – Corporate Directorate sickness data with absence end date between 1 April 2025 and 6 May 2026

Days taken to enter sickness within the Electronic Staff Record (ESR)

Days to Enter	Number of Records	% of Total
0	705	27.0%
1–7	697	26.7%
8–14	343	13.1%
15–21	250	9.6%
22–28	262	10.0%
29+	355	13.6%
Grand Total	**2,612**	**100.0%**

- Five records excluded from the summary as the Days to Enter are negative days with entry prior to the absence start date.

Total Absence Estimated Cost by Organisation L5 (High level cost centre)

Organisation L5	Total Absence Estimated Cost
050 Nursing Executive (YX21) L5	£857,458.53
050 Chief Digital Information Officer (YX40) L5	£697,782.33
050 Public Health Executive (YX41) L5	£631,801.51
050 Estates and Facilities (YX10) L5	£517,120.02
050 WF & OD Executive (YX31) L5	£372,309.38
050 Chief Operating Officer (YX05) L5	£303,511.43
050 Finance Executive (YX16) L5	£207,298.35
050 Chief Executive (YX01) L5	£191,017.49
050 Medical Executive (YX26) L5	£142,457.50
050 Corporate Governance (YX51) L5	£126,008.70
050 Transformation and Strategic Planning Executive (YX53) L5	£112,651.77
050 Executive Director of Therapies (YX54) L5	£17,229.29
050 Director of Performance (YX18) L5	£9,423.31
Grand Total	**£4,195,418.91**

Absences by First Day Absent (Day of Week)

Day of Week	Total Absences	% of Total
Monday	870	33.2%
Tuesday	615	23.5%
Wednesday	469	17.9%
Thursday	384	14.7%
Friday	251	9.6%
Saturday	13	0.5%
Sunday	15	0.6%
Grand Total	**2,617**	**100.0%**

Absences by staff group and full time equivalent (FTE) days lost

Staff Group	Total FTE Days Lost	Total Absence Occurrences
Add Prof Scientific and Technic	730.65	29
Additional Clinical Services	1,242.39	127
Administrative and Clerical	13,202.83	941
Estates and Ancillary	2,075.50	116
Medical and Dental	73.40	18
Nursing and Midwifery Registered	4,259.47	248
Grand Total	**21,584.24**	**1,479**

Source: ESR data received from People & OD Directorate 6 May 2026

Findings & Agreed Action Plan

Objective 1: Managers and departments are complying with the procedural requirements of the All Wales Policy. This includes timely recording of sickness, completion of required documentation, appropriate correspondence issued for sickness meetings.	**Reasonable**

A sample of eighteen long-term sickness absence records was selected for review across the Corporate Directorates with evidence requested to support action taken in managing the absence; responses were received for fourteen. Based on the evidence received, the majority of cases demonstrated compliance with the policy. Managers generally maintained regular contact with employees during periods of absence, obtained appropriate medical certification, conducted long-term sickness review meetings, and referred to Occupational Health support where required. In several cases, phased return-to-work arrangements and workplace adjustments were implemented to support employees returning to work.

A small number of exceptions were identified, including minor delay in completing meetings or documentation, and one case where a formal return-to-work record had not been completed. These issues did not indicate significant weaknesses in the overall management of the absences reviewed.

Overall, the sample of absences reviewed provides reasonable assurance that long-term sickness absences are generally being managed in accordance with the NHS Wales Managing Attendance at Work Policy, with evidence of a supportive and proportionate approach to employee wellbeing and attendance management.

Objective 2: Where there has been referral to Occupational Health, appropriate support is available to managers and staff, and the service has been effective in reducing absence.	**Reasonable**

The Managing Attendance at Work Policy outlines where a referral to Occupational Health should be considered by management. Our sample testing show that where Occupational Health referral was required, referrals were either completed or alternative arrangements were already in place e.g. subject to reviews by a Doctor/sought alternative support that did not result in a referral. We are advised that, where occupational health reports had been received, actions set out in the reports were implemented by management. We found four instances where we were advised referral was discussed but declined by the individual and not progressed - NHS Wales Managing Attendance at Work Policy – Section 5 Occupational Health provides for the manager to refer without the employee's consent (section 1.2).

A survey was issued to collect line manager feedback on the effectiveness of sickness absence management arrangements, including Occupational Health (OH) referral process. The survey results demonstrated a good understanding of Occupational Health (OH) referral requirements, with 92% confirming they knew when referrals should be made with positive comment on access to OH services (63%) and timeliness of response (66%) however there was a notable decrease to 55% of respondents finding the reports from OH of use.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Occupational Health (OH) reports** The survey results demonstrate overall positive line manager experience in the use of the Health Board's Occupational	There is an increased risk of:	**Agreed Action:** Occupational Health will survey line managers and HR colleagues to gather feedback on OH reports to aid improvement. This will be

	Health Service. However feedback indicates the usefulness of the reports requires review to ensure they are of benefit to both the employee and service. Some employees declined referral to the Occupational Health Service, which management supported, despite the all-Wales Policy implying this to be "In very rare circumstances…". Our sample noted 29% did not refer.	▪ Inconsistent application of all-Wales policy. ▪ Inequality in the treatment of sickness absence with no independent review of management actions, increasing the risk of litigation with prolonged sickness absence impacting the delivery of services.	an ongoing action; however, survey results will be monitored on a quarterly bases for action and improvement. **Expected Evidence of Implementation:** ▪ Feedback is provided by line managers and People & OD when Occupational Health reports lack workable or helpful guidance to enable an employee's return to work.
		Medium Priority	**Officer:** Assistant Director of Occupational Health, Safety and Security
	Theme: Policies & Procedures	Control Operation	**Target Implementation Date:** 1st August 2026

Objective 3: Appropriate training is made available to all managers who have a responsibility for managing staff.	**Reasonable**

A formal Managing Attendance at Work (MAAW) training programme is available to all managers and supervisors with attendance management responsibilities. Training covers the requirements of the attendance management policy, formal process stages, use of managerial discretion, Occupational Health referrals, recording requirements within the Electronic Staff Record (ESR) and the importance of Return-to-Work interviews. Multiple training dates and locations are provided throughout the year to maximise accessibility for managers.

There is also a Managing Attendance at Work Toolkit page on BetsiNet, available to all staff, which includes several guides.

Training is not mandatory and records held by People & OD show that only 25% of eligible corporate directorates employees, designated Agenda for Change Band 7 and above, have taken up the offer of the training either in-person or virtually.

Response to our questionnaire on managing attendance at work conflicted with the availability of training, with 61% advising they have not received training and 89% advising they have not received refresher training.

Key Findings	**Risk & Impact**	**Agreed Management Action**
		Agreed Action:

2	**Managing Attendance at Work Training** There is poor uptake of the training available across the corporate directorates based on the records held by People & OD. Survey results indicated that most managers reported never receiving formal training and very few had participated in refresher training, although we were advised that attendance at Managing Attendance at Work (MAAW) training is currently not mandatory. Although management has implemented a monthly improvement plan to increase Sickness Management training compliance to 100%, current completion rates across corporate directorates managers remain low at 25%. Line managers are responsible for ensuring compliance with the MAAW Policy and response to our questionnaire noted that 82% of respondents advised they felt supported by People & OD.	Managers may apply sickness absence processes inconsistently due to limited training completion, resulting in inequitable management practices and potential employee relations issues.	Training attendance data will be sent to all corporate directors on a quarterly basis. MAAW training to be advertised via the People Managers forum. HR Associate Directors to send the Head of Organisational Development training dates to be advertised via the forum. **Expected Evidence of Implementation:** ▪ Reporting to all Corporate Directorate Senior Leadership Teams from People & OD include MAAW training attendance rates. ▪ Regular publication of training opportunities for MAAW.
		Medium Priority	**Officer:** Senior Head of People Operations, Corporate Services HR Associate Directors Head of Organisational Development
	Theme: Training & Development	Control Operation	**Target Implementation Date:** 31st August 2026

Objective 4: Adequate reporting mechanisms are in place to monitor and manage attendance levels, both locally and at Board level — Reasonable

The audit reviewed arrangements for monitoring sickness absence performance and compliance with attendance management requirements. Management advised that monthly reporting processes are in place to monitor both short-term and long-term sickness absence activity. People & OD Officers review prompt reports and long-term absence reports to identify cases requiring management intervention and to assess compliance with policy requirements. Managers are required to provide evidence of formal sickness absence meetings and demonstrate that appropriate action has been taken where policy triggers have been reached. These arrangements provide an important mechanism for identifying non-compliance and ensuring timely management action.

People & OD (POD) also produce monthly attendance management reports for individual directorates, providing information on sickness absence levels, reasons for absence, staff group analysis, costs, Return-to-Work compliance and training completion rates; we were advised that POD officers are not always invited to attend some Directorate Senior Leadership Team meetings to present and highlight issues requiring focus but have not corroborated this.

The People and Culture Committee receive regular reports on attendance and sickness rates via the People Operations Report. To supplement this, the Committee requested and received two deep dive reports into sickness at its meetings on 4 December 2025 (Item PC25.130) and 11 June 2026 (Item PC26.59). Committee Minutes of the December 2025 deep dive confirm its focus on management actions concerning sickness trends, hotspot areas and policy compliance.

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
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Prioritisation of Findings

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

Urgent and Emergency Care: Implementation of Audit Wales actions

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Contents

Review Reference	BCU-2526-20
Fieldwork	March – May 2026
Executive Sign Off	10 June 2026
Audit Committee	August 2026
Executive Lead	Tehmeena Ajmal, Chief Operating Officer
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Audit Wales review 'Urgent and Emergency Care: Arrangements for Managing Demand', which was undertaken in 2024/25 and published in July 2025. The conclusion of the report was '*Overall, we found that whilst plans for managing urgent and emergency care demand continue to develop, performance remains extremely challenging and arrangements for managing risks, demonstrating the use of additional funding and patient and staff engagement need strengthening'*

The report identified fifteen recommendations, with implementation dates ranging from quarter 3 2025/26 to quarter 1 2026/27. This audit has considered the management updates provided, and the information available to support these.

Overview

There is a recognised improvement in the governance arrangements for Urgent and Emergency Care (UEC), noting the appointment of a programme lead, established workstreams and programme reporting. There is regular reporting of performance and priorities at Board and Committee level, however, it is recognised that performance is significantly outside national targets for a number of areas. Progress has been made in ensuring plans reflect priorities, identification of local actions, and oversight and monitoring of progress with the UEC Programme. Further work is ongoing to refine the corporate and Board Assurance Framework (BAF) risks relating to UEC, and progressing the work of the UEC Programme workstreams, which cover the areas highlighted in the Audit Wales report.

The Six goals plan for 2025/26 was not formally approved by the national team, however the plan for 2026/27 has been approved, with additional 90-day plans in place to address key areas of underperformance.

The table below illustrates the status of the agreed actions – it should be noted that two actions are not yet due for completion.

	High
Closed	7
Partially Implemented	6
Outstanding	2
Total	**15**

We have not provided further recommendations, as recognise those partially implemented and outstanding are being progressed.

Status of Previously Agreed Recommendation

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
1.	**Recommendation** To ensure that priorities reflect and align to up to date information such as service demand, service capacity and future demographic pressures, the Health Board should clearly indicate the data used to inform its plans for urgent and emergency care. **Management response** The 6 Goals Delivery Plan includes specific benefits and measures to monitor the progress against the priorities for the 4 UEC workstreams. A number of Power BI dashboards have also been established to support access to a range of live data across UEC, enabling oversight of activity across acute and community sites, any emerging pressures and monitoring delayed patients. UEC data will be reviewed within the IHC local governance structures for UEC, the UEC programme board and UEC internal focus group to continue to inform plans and priorities.	UEC Programme Director Q3 2025-26	**Closed** A six goals delivery plan is in place that sets out the key priorities of Urgent and Emergency Care (UEC). The plan describes activities, workstreams, and deliverables, although it does not reference data used to inform the plan. However, alongside the six goals plan, there is a 90 day UEC improvement plan that includes trend data and details key UEC targets for immediate delivery, including ambulance handover >45 mins; median time from arrival at ED to triage by clinician; median time from arrival at ED to assessment by clinical decision maker; reduction in numbers waiting > 4 hours; reduction in numbers waiting 12 hours and a reduction in number of POCDs. The Integrated Medium-Term Plan (IMTP) also sets out the priorities for UEC within the strategic priority 'Timely Access to Care', which references the six goals for UEC programme.
2.	**Recommendation** To strengthen risk management, the Health Board should ensure that all risks set out in urgent and emergency care plans have risk owners, clear scores and targets as well as robust mitigating actions. **Management response** The 4 UEC workstreams have RAID logs that are either developed or in development that include risks, actions, issues, decisions which are reviewed during each workstream meeting that are held regularly with standard agendas. A Health Board corporate risk CRR25-01 (Timely Patient Access to Safe & Effective Care) includes mitigating actions and controls across UEC as well as wider services.	UEC Programme Director / relevant risk leads Q4 2025-26 Q1 2026-27	**Partially implemented** The workstreams within the UEC programme provide highlight reports to the programme board that include the risks for each of the workstreams. A Programme risk report is also presented at the UEC board meeting. This outlines the risk, mitigations, score, risk owner and next review date. It also categories the risk. Operational risks are managed through the Operational Leadership Team. The BAF risk (BAF24-07) and corporate risk (CRR25-01- Timely Patient Access to Safe and Effective Care) continue to be reviewed and refined.

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
3.	**Recommendation** To ensure that the actions taking place within Integrated Health Communities align with the corporate vision of the Health Board, it should develop IHC delivery plans to implement the vision of the corporate Six Goals Plan which sets out a consistent approach to track performance of the overarching urgent and emergency care plan delivery across each IHC area. **Management response** The 6 Goals transformation programme and delivery plan is a single regional plan which will be delivered within each of the IHCs (as the current service configuration) to ensure consistency of approach. This will include a detailed deployment / implementation plan across different sites and services rather than having three additional locality-based plans. The rationale for this is to ensure development of a single model for the Health Board to drive out unwarranted variation.	UEC Programme Director Q4 2025-26	**Partially implemented** Each of the IHCs attend the UEC Programme Board to report on progress / issues. The meetings also include a review of 90 day plans that align with the overall UEC 90 day plan. All sites also have monthly strategic UEC meetings. We reviewed the 90-day plan for West IHC, which included detailed actions and timescales. It is recognised that work is continuing to develop a single organisational plan for UEC in line with reconfigured services as part of Foundations for the Future.
4.	**Recommendation** To provide clarity on how initiatives will be funded beyond the annual plan cycle, the Health Board should ensure its plans for urgent and emergency care clearly identify funding needs for current and future years, as well as identifying the sources of funding. **Management response** Additional 6 Goals funding has been made available nationally, which is contingent on a detailed financial plan, and which has been submitted to the national NHS P&I team. As regional service models are developed, resource implications will be integrated into annual financial plans and within the IMTP.	UEC Programme Director Q4 2025-26	**Partially implemented** The six goals plan identifies funding needs for 2026/27; however it does not detail future year funding. We are advised that the Health Board are working with the national Performance and Improvement team on UEC priorities for future funding.
5.	**Recommendation** To support achievement of the ambitions of its urgent and emergency care plans, the Health Board should clearly set out the current and future workforce requirements. **Management response**	UEC Programme Director Q4 2025-26	**Outstanding** There has not been progress in workforce planning; this will be progressed following Foundations for the Future, which will have an impact on the delivery of services and staffing.

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	Workforce requirements will be assessed as part of the development of a regional model for urgent and emergency care and to support requirements of R4.		
6.	**Recommendation** To help guide patients to the most appropriate service for their needs, the Health Board's website should include advice on key urgent conditions, such as breathing difficulty, chest pain or rashes. **Management response** The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the 'Help Us Help You' campaign.	Director of Communication Q3 2025-26	**Closed** The Health Board website has a section titled 'Health Advice', which includes advice for patients on various conditions. The website also includes a 'where to go' section that directs patients to pharmacies, NHS 111 and Minor Injuries Unit. The NHS 111 Wales website includes a symptom checker. An approved UEC communications plan is also in place, which includes a communications activity scheduled for stakeholders, including public, staff and Welsh Government.
7.	**Recommendation** To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance. **Management response** The BCU website includes information about local primary care services; including access to dental and GP services that includes a page with a directory of information of all GP practices in NW as a core part of seasonal campaigns to sign post to information. The website also includes a link to NHS 111 providing information and a point of signposting which includes all directories for primary care services and is the single point of contact in terms of supporting the public with decisions on these services. The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help	Associate Director of Primary Care / Corporate Comms Q3 2025-26	**Closed** As noted in action 6 above, a communications plan is in place which includes communication activity to GPs. We reviewed five GP surgery websites, and all had information regarding out of hours / urgent care services.

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the 'Help Us Help You' campaign.		
8.	**Recommendation** To support staff and public understanding of the breadth of urgent and emergency services within the Health Board, and how to access them, the Health Board should develop a communications plan for urgent and emergency care services. **Management response** The BCU website includes information about local primary care services; including access to dental and GP services that includes a page with a directory of information of all GP practices in NW as a core part of seasonal campaigns to sign post to information. The website also includes a link to NHS 111 providing information and a point of signposting which includes all directories for primary care services and is the single point of contact in terms of supporting the public with decisions on these services. The Health Board publishes a regular schedule of advice and information about how to access urgent care appropriately and where more information about services and checking symptoms can be found. This is part of a year-round approach to help improve public understanding of services and influence behaviour when people need urgent care and support. This local activity is supported by national campaigns, such as the 'Help Us Help You' campaign.	Director of Communication Q4 2025-26	**Closed** An approved UEC communications plan is in place, which includes a communications activity schedule for stakeholders, including public, staff and Welsh Government.
9.	**Recommendation** To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task. **Management response** A clinical lead has been identified to roll out our Single Point of Access model, which includes an accurate and up to date directory	Clinical lead for UEC Q4 2025-26	**Partially implemented** A clinical lead has recently been appointed to provide specific focus on the implementation of a single point of access; work is ongoing via Workstream 1 of the UEC programme to progress this.

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	of services to support referral into appropriate services. This will initially be supported by the 6 Goals project team. The lead role will be designated following the reconfiguration of services.		
10.	**Recommendation** To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee. **Management response** As part of the 6 Goals programme a review will be undertaken to evaluate the SDEC models currently in place on each of the 3 acute sites in North Wales, including an analysis of utilisation by WAST and ED to support streaming, and outcomes for patients. The NHS P&I team are conducting an assurance review of the SDEC units during October 2025.	Clinical lead for UEC Q4 2025-26	**Partially implemented** The national Performance and Improvement (P&I) Team undertook a review of Same Day Emergency Care (SDEC) in 2025/26, which made several recommendations. These have informed planning for 2026/27 and have been included in Workstream 2 of the UEC programme Reporting to the Health Board states that 'Despite progress in protecting SDEC capacity across all sites, current performance data does not yet demonstrate the expected increase in SDEC utilisation. In addition, clinical feedback indicates variable confidence in SDEC being used as a robust and reliable alternative to medical referral or hospital admission across pathways and specialties.' The Programme team continue to work with the national P&I team to progress the priorities for this workstream to develop the acute model in North Wales.
11.	**Recommendation** To ensure Urgent Primary Care Centres are being maximised, the Health Board should: 11.1 Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria. 11.2 Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed. **Management response** BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	UEC Programme Director / workstream lead / clinical lead Q1 2026-27	**Outstanding** The Health Board is working with the national Performance and Improvement team to develop the acute model in North Wales.

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
12.	**Recommendation** To understand how well it is utilising Minor Injuries Units and to identify further opportunities to maximise this service, the Health Board should include metrics on attendance and conveyance rates to its minor injuries units and medical assessment units in reports to the Finance and Performance Committee. **Management response** A power BI dashboard is established that includes a suite of reports for MIU performance data including number of attendances, time to triage & clinician / number of breaches. UEC data will be reviewed and scrutinised within the UEC programme board and other relevant forums as agreed with the COO to inform the development of plans and priorities.	Chief Operating Officer Q3 2025-26	**Partially implemented** The Performance report to the Performance, Finance and Information Governance (PFIG) Committee includes metrics on number of waits in Emergency Departments (ED) and Minor Injury Units (MIUs) but does not provide a further breakdown. However, the Committee do receive regular updates on UEC. We are advised live MIU data is available, and performance reviewed at the daily system resilience call.
13.	**Recommendation** To ensure future plans for urgent and emergency care are informed by patient experience, the Health Board should clearly demonstrate within the narrative how it has considered patient feedback. **Management response** The UEC programme board receives a patient story as a standing item on the agenda. A review of complaints and compliments is routinely undertaken by IHCs respectively. As part of the focused work within UEC workstream 4, Discharge Improvement Groups have been established in each of the 3 IHCs to review discharges that are considered to provide learning, identify themes and trends. Targeted work has been done with care homes and actions to improve the patient experience which is included within care home awareness seminars.	Chief Operating Officer Q3 2025-26	**Closed** Patient stories are included as a standing agenda item for the UEC Programme Board to share learning and good practice. Patient feedback has been used to inform the plans within workstreams, for example: UEC workstream 4 (Discharge from Hospital) includes feedback on policy and actions to make letters to patients easier to understand. UEC Workstream 2 (Implement Single Point of Access Framework) included a case study of 5 patients to inform pathway redesign).
14.	**Recommendation** To improve the understanding of how services are working, and identify potential weaknesses or learning from recent changes, the Health Board should introduce regular mechanisms for staff feedback on urgent and emergency care services. This should	Chief Operating Officer Q3 2025-26	**Closed** As noted in recommendation 8 above, there is a communication plan in place to include feedback from staff and partners. Observations and findings from audits in the Emergency Departments have been reported via the Health Board and have

Ref	Recommendation and agreed action	Original Responsibility & Timescale	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	include feedback from key partners including primary care and WAST staff. **Management response** Follow up audits have been undertaken in the 3 ED departments specifically for attendances from care homes into the EDs. This has included engagement with staff from care homes & EDs. Learning from this has been incorporated into the ongoing care home awareness webinars that are being rolled out across NW within a rolling programme of awareness raising and training.		fed into the priorities for workstreams within the UEC programme.
15.	**Recommendation** To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies. **Management response** The UEC (6 goals) programme board approved the 6 Goals financial plan that is aligned to the 6 Goals programme plan prior to submission to WG earlier this year. The UEC / 6 Goals programme board will receive regular finance reports on UEC / 6 Goals and wider Further Faster / RIF funding as a standing item which includes review with LA partners.	UEC Programme Director / CFO Q3 2025-26	**Closed** The six goals plan for 2025/26 was not approved by the national team. The plan for 2026/27 has been approved, and incudes a financial summary of how the core six goals funding will be allocated across UEC priorities, and how any additional Regional Integration Fund monies will be allocated. There is an established structure in place for reporting on funding / spend – the UEC Programme Board meets monthly, with the May 2026 agenda including an item on 'UEC Programme Money 2026/27', and the Performance, Finance and information Governance (PFIG) Committee receive regular finance reports, and updates on the UEC programme.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

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.

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

Capital Governance Arrangements

Advisory Report

2025/26

Betsi Cadwaladr University Health Board

Advisory Report

Contents

Review Reference	BCU-SSU-2526-26
Fieldwork	December 2025 – March 2026
Executive Sign Off	16th July 2026
Audit Committee	18th August 2026
Executive Lead	Carol Shillabeer, Chief Executive Officer
Audit Team	Huw Richards, Deputy Director, SSu
	Paul Stocker, Audit Manager

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This advisory review was requested by the Health Board's Chief Executive, recognising the delivery issues (delays/additional costs) arising at the Llandudno Hospital Orthopaedic Development.

It is not intended that this review would replace a formal Post Project Evaluation of the Llandudno Hospital Orthopaedic Development.

The overall objective of this advisory review was to evaluate the arrangements currently in place within the Betsi Cadwaladr University Health Board (herein referred to as the UHB) to successfully oversee and manage major capital projects. The review considered the adequacy of current arrangements, assessed compliance against national guidance, comparisons against best practice examples and where appropriate identified any areas for improvement. This review was also informed by a series of interviews with key stakeholders involved in the capital management processes operating within the UHB (See **Appendix A**).

Overview

The UHB is currently undertaking a review of its organisational structure through the 'Foundations for the Future' strategic redevelopment programme. This programme is expected to result in changes to future arrangements for planning, capital development, and accountability for the delivery of capital projects.

Against this backdrop, this advisory review has identified several key management considerations aimed at strengthening assurance over the governance, management, and delivery of capital projects, and informing future structural and accountability frameworks.

This review represents the second advisory engagement commissioned by the UHB in response to issues arising from the delivery of a major capital project. The first review was undertaken in 2014 following concerns regarding cost escalation and significant governance failings in relation to the Ysbyty Glan Clwyd Redevelopment. A review of the findings from that engagement indicates that many of the issues identified at that time have also been observed in more recent reviews, including the Llandudno Hospital Orthopaedic Development.

Whilst a number of items have been raised for management consideration within this advisory report, the primary issues relate to the need to reset capital governance arrangements, associated procedures and the need to apply clearly defined and accepted roles and responsibilities at the delivery of capital projects/programmes.

Scope & Assurance Summary

	Objectives	Related Considerations
1	**Capital Governance arrangements:** To consider the adequacy and appropriate application of the UHB's existing Capital Governance controls.	1 - 7
2	**Roles and Responsibilities:** To consider the determination, assignment and delivery of key project roles and responsibilities, the allocation and acceptance methodologies and performance review mechanisms etc.	8 - 11
3	**Monitoring and Reporting:** To consider project monitoring and reporting arrangements established within the UHB. To include an assessment of both regular reporting arrangements (approvals, monitoring / project scrutiny, and reporting including quality and regularity of information, standing agenda items, mechanisms adopted) and adequacy of escalation processes etc.	2, 12 - 14
4	**Contractor and Adviser Appointments –** To ensure appropriate mechanisms are applied in the appointment and management of the UHB's project advisers and contractors (when not utilising the NHS Wales National framework arrangements).	15 - 19

Key Considerations

19

Themes

Risk Types

Financial Loss

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Management Considerations

1.0 Capital Governance Arrangements

Objective 1.1: Governance Structures

Overview / Summary of Observations

The UHB is currently reviewing its organisational structure through the Foundations for the Future programme, which is expected to influence future arrangements for planning, capital development and accountability for major capital projects.

The existing governance structure—set out within the Capital Procedure Manual—has been in place for several years and governs the development, approval and expenditure of capital business cases for projects exceeding £5m. The key structure/approval process is summarised below:

Step	Body / Group	Purpose
1	Capital Investment Group (CIG)	Review and approval of scoping document
2	Welsh Government	Approval of scoping document
3	Capital Investment Group (CIG)	Initial review of SOC, OBC and FBC
4	Executive Team	Executive oversight and assurance
5	Performance, Finance Integrated Group (PFIG)	Financial and performance scrutiny
6	UHB Board	Final approval and authorisation

A paper was presented to UHB's Executive Committee on 8 April 2026 seeking formal approval of the revised Executive Delivery Group (EDG) structure. The revised arrangements aim to strengthen Tier 1 governance by "*clarifying decision-making responsibilities, improving alignment with Standing Orders and the Scheme of Reservation and Delegation, and ensuring that papers submitted to the Executive Committee are fully developed and evidence-based.*" The Strategic Planning and Service Change Group (SPSCG) will form one of six core EDGs. The Group will be responsible for the scrutiny, monitoring, and oversight of capital investment projects and programmes. The Terms of Reference were in development at the time of reporting (**MC1**/**MC2**).

A core governance document for every project is the Project Initiation Document (PID) or Project Execution Plan (PEP), which sets out project purpose, scope, governance arrangements and delivery approach. Under PRINCE2 methodology, this should be maintained as a live document throughout the project lifecycle. Previous audits indicate that 50% of major projects reviewed since 2019 had weaknesses in the completeness or quality of their PEPs.

Projects should establish a Project Board (or Programme Board where several related projects exist) at inception (**MC3**). Meetings should be supported by accurate minutes, action logs and timely circulation of papers. Recent audits—including the Llandudno Orthopaedics Project—identified recurring weaknesses, including inconsistent meeting frequency and variable quality of minutes and agendas.

Enhancements to strengthen these governance arrangements have been identified **(See Appendices B,C & D)**.

Management Consideration 1: Formulisation of Key Terms of Reference

The Terms of Reference for the SPSCG should incorporate the specific role and responsibilities for its oversight of capital projects/programmes, and ensure that governance requirements are appropriately communicated and reflected within the UHB's Capital Procedure Manual etc.

Management Response:

The Health Board will review the arrangements for capital in accordance with the Scheme of Delegation and in discussion with the Executive Team on the approach to the management of capital (Director of Environment and Estates) Please refer to **MC12**.

Management Consideration 2: Reporting to Executives

The formal line of sight between capital project delivery and Board level strategic assurance should be strengthened. In particular:

- Reporting expectations at Board level (frequency, format, content) are not clearly defined.
- There is no consolidated capital programme report providing an overview of delivery risk, affordability and interdependencies.
- There is limited evidence showing how project level risks inform the Board Assurance Framework (BAF).

Management Response:

1. Confirmation of the reporting against the Capital Programme for inclusion in the Cycle of Business to the Performance, Finance and Information Governance Committee through reports from the Executive Committee (whilst the arrangements for the management of capital are worked through) (Lead: Director of Environment and Estates)
2. The Board Assurance Framework will be reviewed to ensure appropriate linkage to the Capital Programme and Capital Investment Group (Lead : Director of Environment and Estates)

Management Consideration 3: Project/Programme Boards

Project and Programme Boards should be formally established at project initiation, with clear Terms of Reference, defined membership and agreed meeting schedules. Key governance meetings should occur at a minimum prescribed frequency and be supported by complete and timely minutes capturing decisions, actions, risks and ownership. Periodic quality assurance should be introduced to ensure consistent compliance across all capital projects.

Management Response:

These requirements are to be included within the updated Capital Manual (Lead: Director of Environment and Estates)

Objective 1.2: Policies & Frameworks

Overview / Summary of Observations

The UHB's Capital Procedure Manual, first developed in 2014 and last updated in December 2020, no longer reflects current organisational structures, operational practices, or external requirements, including the use of updated contractor frameworks and contract forms such as New Engineering Contract (NEC). Recent Internal Audit reviews have also highlighted the need for a comprehensive revision (**MC4**).

Discussions held during this advisory review, including with Executive Directors, confirmed that refreshing the Manual is recognised as a priority. While the Manual is viewed as a key reference document by Senior Project Managers and Project Managers, there is limited evidence of consistent awareness or use across the wider organisation.

Given its purpose—to provide clear and consistent guidance on governance, roles, responsibilities, and processes—it is essential that all staff involved in the initiation, development, and delivery of capital schemes are familiar with the Manual and apply it in day-to-day practice.

The review identified an opportunity to strengthen capital delivery through the introduction of dedicated project management software or standardised project development checklists. These tools would help ensure consistent application of processes across varying delivery frameworks, contracts, and service level agreements.

Development of this would support compliance with Standing Orders and Standing Financial Instructions and help staff navigate evolving procurement requirements, including those relating to the appointment and management of supply chain partners and professional advisers (**MC5**).

Management Consideration 4: Capital Procedure Manual Refresh

The UHB should prioritise updating the Capital Procedure Manual to ensure it reflects current organisational structures, external requirements, and recognised best practice. The revised manual should be supported by improved communication, accessibility, and training to promote consistent understanding and application of capital governance processes across all relevant staff.

Management Response:

The Capital Procedure Manual will be reviewed and implemented (Director of Environment and Estates, December 2026)

Management Consideration 5: Project Management Tools

To develop standard documentation and checklists to comply with both national and local capital delivery requirements and that these should be easily available e.g. via project toolkits etc.

Management Response:

To develop a toolkit with standard documentation to ensure compliance with the Capital Procedure Manual (Director of Environment and Estates, March 2027)

Objective 1.3: Approval Pathways

Overview / Summary of Observations

Experience across NHS and wider public sector capital programmes shows that early-stage business cases are particularly susceptible to optimism bias, including understated costs and risks and overstated benefits and deliverability. Independent validation reviews provide an important early challenge to these assumptions before commitments become difficult or costly to reverse.

The UHB has an established process for developing business cases, supported by the Assistant Director – Strategic and Business Analysis, a qualified Better Business Case Practitioner. This role provides end to end guidance aligned to HM Treasury's Green Book and the Five Case Model. Additional capacity is provided by the Planning Manager within the Planning Team.

Historically, validation reviews undertaken by Executive and senior management provided independent challenge to project proposals, helping to counter optimism bias and prevent consensus forming without sufficient scrutiny (**MC6**).

These reviews formed an important control to ensure projects were not progressed prematurely without adequate due diligence and stakeholder engagement. In their absence, there is an increased risk that projects may advance on the basis of untested assumptions, with potential downstream implications for affordability, deliverability and overall outcomes. Issues arising from the expedited Llandudno Project illustrate the consequences of insufficient early-stage challenge (**MC7**).

The 2024 audit of the Llandudno Orthopaedics Project also identified delays and inefficiencies in the approval of contract awards, with multiple work packages awarded separately to the same Supply Chain Partner.

Previous reviews have also highlighted inconsistent use of formal change control processes; for example, three variations exceeding £150k in the 2025 Llandudno review lacked adequate audit trails demonstrating compliance with the Capital Procedure Manual and Standing Orders/Standing Financial Instructions.

Management Consideration 6: Business Case Validation Reviews

The UHB should reinstate validation reviews to reinforce a structured, stage-gated approach to capital investment. This would help ensure that projects progress only when they remain achievable, affordable, aligned to strategic priorities, and supported by robust and tested assumptions.

Management Response:

It is acknowledged that there is no current gateway review process associated with capital investment together with an inconsistent approach to developing business cases with confusion regarding the use of SBAR's often confused with business cases. The updated Capital Procedure Manual will provide guidance on the core requirements for business cases based on a scaled version of the 5-case model with internal gateways and reporting. (Director of Environment and Estates, December 2026).

Management Consideration 7: Business Case Sign Off

Executive leads should provide clear sign-off, acceptance, and ownership of their respective components of each business case (e.g., service, finance, IM\&T, estates). This should complement existing committee approvals and ensure stronger accountability across all functional areas.

Relevant national guidance includes:

- NHS Wales Infrastructure Investment Guidance;
- NHS Building for Wales Framework Guidance;
- NHS Wales Capital Investment Manual;
- Better Business Cases and
- National Infrastructure and Service Transformation Authority etc.
- Construction Playbook

Management Response

The business cases presented to HB are signed off by the relevant governance forums in accordance with the Scheme of Delegation and reflected in the updated Capital Manual.

2.0 Roles and Responsibilities

Objective Finding 2.1: SRO and Project Director

Overview / Summary of Observations

The Senior Responsible Officer (SRO)—referred to as the Project Executive in PRINCE2—is the single point of accountability for a capital project and is responsible for ensuring its successful delivery. The UHB's Capital Procedure Manual states that the SRO must ensure the project meets its objectives, delivers the required outcomes, and realises the intended benefits. The role requires strategic leadership, active sponsorship, and sufficient seniority to influence decision making across organisational boundaries.

The Manual requires the Chief Executive to identify an SRO for all capital projects over £1m, with seniority determined by project value.

Threshold	SRO
£1m to £5m	Senior Manager
£5m to £10m	May be senior manager or executive director dependent upon the complexity and/or risk of the project
Above £10m	Executive Director

SROs are expected to be appointed for the full project lifecycle, with responsibilities, authority, time commitment and handover arrangements clearly documented.

The Project Director is responsible for day-to-day operational delivery. Early appointment of an experienced Project Director is essential for establishing effective controls, maintaining momentum, and ensuring clear accountability. Continuity in this role supports programme stability and delivery confidence.

Concerns raised at the Capital Investment Group (May 2025) noted that three Integrated Regional Care Fund major capital projects were progressing without an appointed SRO. A 2024 Gateway Review also identified weaknesses in SRO arrangements. The Building for Wales 2 Framework reinforces the importance of timely Project Director appointment and sustained oversight. Similar issues were highlighted in the 2025 Orthopaedic Surgical Hub Llandudno Hospital Audit Report (**MC8**).

Management Consideration 8: SRO and Project Director Roles

Capital project governance would benefit from more consistent and formalised arrangements for appointing and operating both the SRO and Project Director roles. Management should:

- Clearly document the appointment process, delegated authority, tenure expectations and handover arrangements, supported by a Responsible, Accountable, Consulted, Informed (RACI) matrix to define responsibilities and decision-making authority.
- Identify and provide any required training or structured support to ensure individuals in these roles are fully equipped to meet their responsibilities.

Improved clarity and capability across these key roles would strengthen decision making, continuity, and assurance over major capital project delivery.

Management Response:

This recommendation is accepted; the documentation review should clearly indicate the governance forum in regard to the appointment and responsibilities for the SRO and Project Director roles. To include the scope of what is being required for each of the projects. This will be reflected in the updated Capital Procedure Manual with staff training supplemented.

Objective 2.3: Role Clarity & Segregation of duties

Overview / Summary of Observations

This advisory review examined the roles, responsibilities, and capacity of UHB staff involved in the day-to-day management and delivery of capital projects.

Responsibility for capital delivery sits within the Directorate of Environment and Estates. While the Director has a broader remit beyond capital, accountability for capital projects is exercised through established governance and management arrangements.

Operational capital project delivery is led by the Head of Capital Development, who is responsible for the discretionary capital programme, chairs the Capital Planning Management Team (CPMT), and represents the UHB at Welsh Government and NWSSP:SES forums. Monthly updates on capital activity and progress are reported to the Capital Investment Group (CIG).

The UHB operates across three geographical areas—West, Central, and East—with a Senior Project Manager assigned to each. These managers' report directly to the Head of Capital Development and oversee day to day management of their allocated schemes. Each is supported by a Project Manager, an Assistant Project Manager, and administrative staff.

Team members generally hold appropriate professional qualifications, with Assistant Project Managers forming part of longer-term workforce development plans. Capacity is supplemented by a specialist Project Manager for radiology related schemes and two in house mechanical and electrical engineers who act as supervisors for non-Building for Wales (B4W)2 projects.

Team members reported confidence in managing Joint Contracts Tribunal (JCT) contracts but identified a need for additional training and ongoing professional development in NEC contract management, which is the standard form under the B4W2 framework. Strengthening NEC contract knowledge would enhance project administration, risk management, and compliance. Training requirements should be routinely captured through annual personal development reviews. (**MC9**)At the time of review, the team was supporting more than 70 capital projects. Although IRCF funded schemes were intended to have dedicated project managers, resource pressures have required these schemes to be absorbed into the existing workload. While the team is experienced and professional, overall capacity is constrained by the volume and complexity of projects and by the need for Senior Project Managers to provide additional oversight and support to less experienced colleagues. A comprehensive workforce review has not been undertaken recently. Such a review would help assess current capability and capacity, determine future workforce requirements, and ensure the estate is maintained effectively without compromising future investment (**MC10**).

Management Consideration 9: Training Needs Analysis

Training needs should be clearly identified through annual appraisals (including contract/procurement requirements).

Management Response:

Agreed but the Training Needs Assessment relates to all staff working on capital projects, including digital and operational, finance and planning colleagues. Action: Director of Environment and Estates to facilitate

Management Consideration 10: Review of Resources

A capital/estates workforce review should be undertaken to analyse the current position in terms of capability, capacity, and future requirements. Following this, a clear financial model for the revenue support needed in the estate should be developed.

Management Response:

Agreed. Action: Director of Environment and Estates. Timescale January 2027 pending Foundations for the Future impact for relevant banded staff.

Objective 2.4: Documentation & Accountability

Overview / Summary of Observations

Roles and responsibilities for capital project delivery are defined through several mechanisms. For substantive UHB Capital staff, job descriptions generally outline expectations for project management and delivery.

However, for key stakeholders at Project Board level—such as Senior Responsible Owners (SROs) and Project Directors—responsibilities are not always formally documented due to the absence of role acceptance or appointment records. This can lead to inconsistent understanding of responsibilities across individuals and projects (MC7). Similar gaps apply to other board or team members providing oversight or specialist input.

Responsibilities are also expected to be defined within the Project Initiation Document (PID) or Project Execution Plan (PEP). These documents, typically produced by contract administrators or advisers, are often generic and do not provide sufficient clarity on decision making authority or accountability. Audit reviews also found limited evidence that PIDs/PEPs are routinely updated to reflect changes in governance, roles, or project requirements (**MC11**).

Overall, governance arrangements rely heavily on the experience and goodwill of individuals, rather than consistently applied, documented processes. This presents risks where roles change or projects increase in complexity.

Management Consideration 11: PIDs/PEPs

The organisation should strengthen the development and ongoing maintenance of PIDs/PEPs by introducing minimum quality standards, defined review and update requirements, and clear accountability for their accuracy. These documents should remain current, complete, and actively used as core components of project governance and assurance throughout the project lifecycle.

Management Response:

Agreed and to be reflected within the updated Capital Procedure Manual. Action: Director of Environment and Estates.

3.0 Monitoring and Reporting

Objective 3.1: Programme/Project Reports

Overview / Summary of Observations

Audit work undertaken over a number of years has identified the provision of project highlight reports, cost reports, project management reports, and supply chain partner reporting across major capital projects. Reporting formats and frequency have remained broadly stable, providing a common basis for monitoring progress, cost, and delivery risks.

Project reporting had generally been produced on a regular and predictable cycle, supporting routine review by Project Boards and other governance forums. This had provided stakeholders with ongoing visibility of project status, progress against milestones, and key issues.

Across the reporting reviewed, there was consistent inclusion of core delivery information, including cost position, forecast outturn, programme milestones, and high-level risks. Supply chain partner reports generally aligned with internal reporting, enabling triangulation of delivery information.

The reporting arrangements in place appear well embedded as part of routine project management activity. However, evidence suggests that reporting is primarily focused on status updates rather than being consistently used as a forward-looking governance tool to support challenge, decision-making, and assurance.

Audits undertaken in respect of the Llandudno Orthopaedic Project observed limited regular reporting beyond the Project Board.

While reporting was generally consistent in structure and content, the level of narrative insight and explanation varied between projects. In some cases, reports focused on factual updates with limited commentary on the implications of issues, risks, or changes for overall project objectives.

See **MA2** re: Executive/ Committee reporting.

Objective 3.2: Board & Committee Oversight

Overview / Summary of Observations

A monthly Capital Programme Report is produced by the Capital Accountant and Head of Capital and submitted to the Capital Investment Group (CIG). The report provides an update on the approved capital programme, including exception-based updates on major schemes and expenditure against the Welsh Government set Capital Resource Limit (CRL).

This report was previously a standing item at the Performance, Finance and Integrated Governance Committee; however, only selected elements now feature within the Director of Finance's routine report. The remit of the recently formed Strategic Planning Service Change Group (SPSCG) in relation to capital projects—particularly those aligned to wider clinical programmes—remains under development.

Previous assurance work indicates that CIG discussions tend to focus on smaller discretionary schemes and leases. While major business cases are submitted to the Group, evidence of systematic scrutiny or challenge is limited. Best practice within other NHS Wales organisations includes operating a broader capital board that brings together senior leadership and an Independent Member to strengthen oversight (**MC12**).

Management Consideration 12: Capital Board

The UHB should consider establishing a dedicated Capital Board as a formal sub-committee of the Board. This would align with effective models used elsewhere in NHS Wales and would include senior leadership and an Independent Member to strengthen scrutiny of major capital schemes. Introducing this structure would improve visibility, governance, and assurance and would complement the role of the Strategic Planning Service Change Group. An example Terms of Reference and sample Agenda is provided at **Appendices B & C.**

Management Response:

Accepted noting that the Executive Delivery Groups do not include Capital. The Performance, Finance and Information Governance Committee currently hold this responsibility.

Objective 3.3: Quality & Assurance

Overview / Summary of Observations

The UHB applies the Three Lines of Defence model, as outlined in the Capital Procedure Manual, to provide structured operational, oversight, and independent assurance.

First Line of Defence – Operational Management

Operational assurance is delivered through the Project Board, Project Team, and where applicable, the Project Supervisor. While the UHB benefits from experienced engineers, the Llandudno Project highlighted areas requiring improvement, including timely updates of required certifications and gaps in specialised assurance.

Second Line of Defence – Internal Governance

Oversight is provided through the Board and its sub committees. Ongoing organisational changes may alter future governance arrangements for major capital projects.

Third Line of Defence – Independent Assurance

Independent assurance is provided through Internal Audit, Gateway Reviews, and other external scrutiny. The Llandudno audit identified limited evidence of routine reporting to Executive Directors and the Board, indicating a need for stronger visibility and higher quality governance reporting.

Integrated Assurance and Approval Plans (IAAPs) are required under *NHS Wales Infrastructure Investment Guidance;* however, their development has been inconsistent (**MC13**). National expectations also include proportionate use of audit, Gateway Reviews, post project evaluations, and lessons learned. PRINCE2 similarly emphasises early consideration of lessons from previous projects (**MC14**).

Management Consideration 13: Integrated Assurance and Approval Plans

The UHB should ensure that Integrated Assurance and Approval Plans are fully developed and included within all business case submissions to Welsh Government, in line with *NHS Wales Infrastructure Investment Guidance*.

Management Response:

To be included as a requirement within the updated Capital Procedure Manual with links to be agreed to BAF and Capital Investment Board. Lead: Director of Environment and Estates

Management Consideration 14: Post Project Evaluations

Assurance across all three lines would be strengthened through consistent completion of post project evaluations, lessons learned reviews, audit actions, and performance reporting. Consolidating these outputs and using them to inform the development of future schemes would enhance operational oversight and support continuous organisational learning.

Management Response:

To be included as a requirement within the updated Capital Procedure Manual with links to be agreed to BAF and Capital Investment Board. Lead: Director of Environment and Estates

4.0 Contractor and Adviser appointments

Objective 4.1: Procurement Pathways, Contract Strategy & Market Engagement

Overview / Summary of Observations

NHS Wales organisations use a range of procurement frameworks and mechanisms to appoint professional advisers and Supply Chain Partners (SCPs). These include national and regional frameworks, call off arrangements, specialist multi-disciplinary frameworks, and open market procurement where appropriate. The introduction of the Procurement Act 2023 (effective February 2025) places greater emphasis on social value, sustainability and SME participation through the Most Advantageous Tender (MAT) approach.

A range of contract forms may be applied depending on project scale and risk. Under Welsh Government frameworks such as Design for life (D4L) / B4W2, NEC4 ECC Option C is the standard form for SCP appointments, with NEC4 PSC used for professional advisers. JCT contracts and SLAs continue to be used for smaller or lower risk schemes, although SLAs offer reduced protection compared to formal NEC/JCT contracts.

Previous assurance work has identified recurring weaknesses, including:

- use of contract forms not aligned to project complexity (e.g. JCT at the Llandudno Orthopaedics Project);
- incomplete adviser appointment documentation;
- use of local frameworks beyond intended scope; and
- repeated absence of signed contracts prior to works commencing.

Market engagement reviews also indicate limited competition for some adviser roles. For example, a Cost Adviser ITT attracted eleven expressions of interest but resulted in only three acceptable bids, contributing to ongoing reliance on a small supplier base.

These issues highlight the need for a more consistent, strategic, and market aware approach to procurement and contracting (**MC15/16/17**).

Management Consideration 15: Procurement Pathways

Procurement routes should be selected as part of a broader contracting strategy, assessing the advantages and disadvantages of all available options.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates

Management Consideration 16: Contract Strategy

All projects should adopt a clear contract strategy identifying the most appropriate contract form, with decisions supported by specialist advice and aligned to project complexity, risk, and governance requirements.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates.

Management Consideration 17: Market Engagement

Management should review factors contributing to limited adviser tender responses—such as market engagement, scope, commercial terms or contract duration—to broaden competition and strengthen value for money.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates.

Objective 4.2: Performance Management

Overview / Summary of Observations

The Construction Playbook sets clear expectations for performance management across public sector construction projects. It requires contracting authorities to establish measurable performance outcomes and KPIs at contract award, maintain continuous performance monitoring, allocate risk appropriately, and use standardised contract frameworks that support effective evaluation throughout delivery. Clear specifications and well aligned KPIs are essential to drive the behaviours and outcomes required for successful project delivery. When applied consistently, they help minimise unintended incentives and support constructive supply chain collaboration.

The NEC suite provides a structured approach to performance management, including Schedule 3 (Performance Monitoring) and, where relevant, Option X20 (Key Performance Indicators). Under NEC4 Option C, good practice is to use Schedule 3 for general monitoring and reserve Option X20 for a small number of critical KPIs that demonstrably add value. In contrast, JCT contracts do not include embedded KPI mechanisms, meaning performance measures must be added through bespoke amendments or external frameworks. Where these are not formally incorporated, there is an increased risk of inconsistency and reduced enforceability (**MC18**).

Management Consideration 18: Key Performance Indicators

While the UHB should select the most appropriate framework and contract for each project, it is essential that KPIs are applied consistently to monitor adviser and supply chain partner performance.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates.

Objective 4.3: Value for Money

Overview / Summary of Observations

Value for money in appointing the Supply Chain Partner (SCP) is primarily informed by the professional judgement of the UHB's appointed advisers, who establish the cost envelope used to assess bidder submissions.

For the Llandudno Orthopaedics Project, works commenced before the design was fully developed, agreed, and formally signed off. This increased the likelihood of design changes during construction—particularly for Mechanical and Electrical (M&E) systems—leading to:

- Variations priced at premium rates
- Abortive installation works
- Additional design and consultancy costs

These unplanned costs reduce cost certainty and risk undermining the original value for money justification for the project (**MC19**).

Management Consideration 19: Formal Acceptance

Management should ensure that formal sign off and confirmation of readiness to proceed at key project stages—by all relevant parties, including key users, the SRO, Project Director, Finance Lead, and advisers—is clearly documented.

Management Response:

Agreed. To be included as a requirement within the updated Capital Procedure Manual with explanations of requirements, route to advice and governance. Lead: Director of Environment and Estates. See also **MC6.**

Appendix A

Key individuals interviewed as a part of this advisory review

Arwel Hughes	Head of Operational Estates
Carol Shillabeer	Chief Executive
Dan Eyre	Head of Capital Development
Denise Roberts	Head of Capital, Governance & BI.
Fiona Mash	Head of Organisational Portfolio Management Office
Ian Howard	Assistant Director - Strategic and Business Analysis
Iolo Jones	Senior Project Manager
Kevyn Breese	Senior Project Manager
Pam Wenger	Board Secretary
Russell Caldicot	Executive Director of Finance
Ruth Stiles	Senior Project Manager
Stuart Keen	Director For Environment and Estates

Note: Example Documents provided at the following Appendices have been shared with kind permission.

Appendix B
Capital Sub Committee – Example Agenda

1 - Meeting Governance

1.1 - Apologies

1.2 - Declaration of Interests

1.3 - Minutes of Previous Meeting

Attachments

1.3 - DRAFT Capital Sub Committee Minutes (Previous meeting)

1.4 - Matters Arising from previous meeting

1.5 - Committee Key Actions

1.6 - Capital Sub-Committee Annual Report 2025-26

2 - Capital Planning, Monitoring & Governance

2.1 - Capital Resource Limit, Capital Financial Management and Capital Programme 2025/26

Attachments:

Paper 2.1a - Capital Update

Paper 2.1b - Annex 2 - Sealing schedule

2.2 - Capital Projects Governance

Attachments:

Paper 2.2a - Capital Governance Report March 2026

Paper 2.2b - Appendix 1 - Capital Project Reporting Process

Paper 2.2c - Appendix 2 - Capital Project Highlight Reports – Bi-Monthly Reports

Paper 2.2d - Appendix 3 - Capital Highlight Reports

2.3 - Welsh Government Dashboards

Attachments:

Paper 2.3a - WG Project Dashboards March 2026

2.4 – Targeted Estates Fund Update Report

Attachments:

Paper 2.4a - WG TEF Projects 2025 26 March 2026 (Final)

Paper 2.4b - Appendix 1 TEF Tracker February 2026

2.5 - Capital Programme 24-25 Lessons Learnt Update

Attachments

Paper 2.5 - Capital programme 24-25 lessons learnt - March 26

2.6 - Capital Planning Group & Capital Monitoring Forum Terms of Reference for approval

Attachments

2.6a - Capital Planning Group ToR v6

2.6b - Capital Monitoring ToR V5 March 2026

3 - Capital Planning Developments

3.1 – Major Programmes

Attachments:

3.1 – Major Programmes Update Feb 26

3.2 - Infrastructure Investment Plan

3.2 - Arts and Health Update

Attachments:

3.2 - Improving_Healthcare_Environments_Presentation

4 - Papers for Information

4.1 – Welsh Government Capital Review Meeting

4.2 - Capital Planning Group

4.3 - Capital Monitoring Forum

Attachments:

Paper 4.3a – Capital Monitoring Forum Minutes 11th November 2025 (Final)

Paper 4.3b - Capital Monitoring Forum 13th January 2026 (Final)

Paper 4.3c - Capital Monitoring Forum 10th February 2026 (Final)

4.4 - Capital Sub-Committee Terms of Reference

4.5 - Property Lease arrangements update

5 - Any Other Business

6 - Date & Time of Next Meeting

Appendix C

Capital Sub Committee – Example terms of reference

CAPITAL SUB-COMMITTEE

1. Constitution

The Capital Sub-Committee (CSC) has been established as a Sub Committee of the Board and constituted from (x date).

2. Membership

2.1 The membership of the Sub-Committee shall comprise:

Title

Executive Director of Strategy and Planning (Chair)

Assistant Director of Strategic Planning and Development (Deputy Chair)

Independent Member

Director of Estates or Deputy

Programme Director(s)

Discretionary Capital Projects Manager

Head of Property

Senior Business Partner (Finance) (Delegated on behalf of the Director of Finance)

Head of Facilities

Deputy Director of Operations

Assistant Director, Medical Directorate (Delegated on behalf of the Medical Director)

Digital Director

Assistant Director of Primary Care

Assistant Director of Assurance and Risk

Head of Procurement

Head of Capital Planning (Sub Committee Lead)

Chair of Medical Devices Group

Director of Nursing and Control of Infection representative

In Attendance

Committee Support/Secretary

Head of Internal Audit (or representatives)

Director of Mental Health and Learning Disabilities

Capital Programme Manager

General Manager, Women and Children's Directorate

Head of Radiology

Project Manager, Capital Planning

Head of Pathology

Head of Property Performance

Capital Programme Manager, Regional Partnership Board

Clinical Director of Pharmacy and Medicines Management

Head of Maintenance and Engineering

Papers sent for Information

Clinical Care Group Service Directors – Community and Integrated Medicine

Assistant Directors

2.2 The membership of the Capital Sub-Committee will be reviewed on an annual basis.

3. Quorum and Attendance

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

An Independent Member shall attend the meeting in a scrutiny capacity. The scrutiny role of Independent Members on Sub-Committees is to ensure their effectiveness in terms of processes and outcomes, and in particular that their work is organised and undertaken in accordance with their terms of reference, that they have clarity about the limits of their delegated powers and responsibilities, and that they understand fully their relationship with and reporting responsibilities to their parent Committee.

Any senior officer of the University Health Board or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

The Sub-Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

Should any member be unavailable to attend, they may nominate a suitably briefed deputy to attend in their place. Where attendance is delegated, the nominated representative is responsible for informing discussions where relevant and reporting back to the named member accordingly.

The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Capital Sub-Committee.

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

4. Purpose

4.1 The purpose of the Capital Sub-Committee is to:

4.1.1 Oversee the delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term).

4.1.2 Recommend to the Board,), the use of the Health Board's Capital Resource Limit (CRL), in line with the HB's financial scheme of delegation

4.1.3 Review, on an annual basis, the Discretionary Capital Programme (DCP) for the following financial year.

4.1.4 Oversee the development of the Estates Strategy and Infrastructure Investment Enabling Plan aligned to the Estate Strategy for consideration by *Board/Committee*, prior to Board approval.

4.1.5 Oversee the development and delivery of implementation plans for the Estates Strategy agreeing corrective actions where necessary and monitoring its effectiveness.

5. Operational Responsibilities

Develop recommendations to the Board, via the *Board/Committee* and Executive Team, on the use of the Health Board's Capital Resource Limit (CRL), for approval.

Develop prioritised recommendations for discretionary capital sums and All Wales Capital Schemes and receive investment proposals, in response to an assessment of the organisation's risks, and to support the Health Board's Estate Strategy (including delivery plans) and vision for healthcare and its strategic objectives, including performance and financial improvement.

Provide a co-ordinated approach to overseeing delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term) enabling the Health Board to understand the overall delivery commitments and risks and proposing changes as appropriate.

Provide assurance that capital projects are managed and governed in accordance with mandatory requirements, best practice and the latest Welsh Government capital guidance, ensuring that revenue consequences associated with capital projects are explicit at project scoping stage.

Provide assurance around the effective management of the Health Board's CRL, ensuring expenditure is in line with Standing Orders and within the agreed programme.

Scrutinise and quality assure major capital business cases prior to submission to *Board/Committee* including those developed in partnership with other organisations such as, Local Authorities, GP partners and Third Sector organisations.

Ensure a robust disposal policy for redundant estate is in place.

Consider options for the acquisition or disposal of estate and agree recommendations for the Board, via the *Board/Committee*.

Review and recommend the appropriate delegated limits for capital expenditure authorisation and authorisation for other funding sources.

5.10 Present and review a schedule of projects/schemes within the Health Board's Capital Plan where there may be associated works contracts that require sealing.

5.11 Make recommendations on capital expenditure in relation to Digital, medical & non-medical equipment, estates statutory and infrastructure, contingencies and other provisions.

5.12 To receive timely post project evaluation and project closure reports which will include a review of the effective application of capital resources and scrutinise the final use against original business justification objectives and monitors the initial improvement impacts of strategic investment.

5.13 Provide assurance to *Board/Committee* that risk is considered as part of prioritisation of capital expenditure items and that where risks are not addressed by capital funding, these risks have been reviewed to assess whether further mitigation actions should be taken (to minimise the impacts should the risk materialise), contingency measures can be strengthened (in case the risk materialises to minimise disruption) and reflect whether the risk is being tolerated or further treated.

5.14 Agree the Annual Audit Plans and monitor action against recommendations contained within audit reports issued by Audit and Assurance.

5.15 To receive regular progress updates on the Housing with Care Fund and Integrated Rebalancing Capital Funds Capital bids and schemes being progressed through the Regional Partnership Board

5.16 Agree issues to be escalated to the *Board/Committee* with recommendations for action.

5.17 Agree an annual work plan for the Sub-Committee for review and approval by the *Board/Committee*.

6. Agenda and Papers

The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and/ or Vice Chair and the Lead Executive/Assistant Director at least six weeks before the meeting date.

The agenda will be based around the Sub-Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Sub Committee members. Following approval, the agenda and timetable for papers will be circulated to all Sub-Committee members.

All papers should have relevant sign off before being submitted to the Sub-Committee Secretary.

The agenda and papers for meetings will be distributed seven days in advance of the meeting.

The minutes and action log will be circulated to members within ten days to check the accuracy.

Members must forward amendments to the Sub-Committee Secretary within the next seven days. The Sub-Committee Secretary will then forward the final version to the Sub-Committee Chair for approval.

7. Frequency of Meetings

The Sub-Committee will meet bi-monthly and shall agree an annual of meetings. Any additional meetings will be arranged as determined by the Chair of the Sub-Committee.

The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary shall determine the time and the place of meetings of the Sub- Committee and procedures of such meetings.

8. Accountability, Responsibility and Authority

The Sub-Committee will be accountable to the *Board/Committee* for its performance in exercising the functions set out in these terms of reference.

The Sub-Committee shall embed the UHB's vision, corporate standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. Reporting

The Sub-Committee, through its Chair and members, shall work closely with the *Board/Committee* and other committees, including joint /sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 joint planning and co-ordination of *Board/Committee* and Committee business;

9.1.2 sharing of information.

9.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The following groups have been established:

9.3.1 Capital Planning Group (CPG)

9.3.2 Capital Monitoring Forum (CMF)

9.4 The Sub-Committee will receive an update following each Group's meetings detailing the business undertaken on its behalf.

9.5 The Sub-Committee will also receive updates from the regular Capital Review meetings held with Welsh Government representation.

9.6 The Sub-Committee Chair, supported by the Sub-Committee Secretary shall:

9.6.1 Report formally, regularly and on a timely basis to the *Board/Committee* on the Sub-Committee's activities. This includes the submission of a Sub-Committee update report, as well as the presentation of an Annual Report within 6 weeks of the end of the financial year

9.6.2 Bring to the *Board/Committee's* specific attention any significant matter under consideration by the Sub - Committee.

10. Secretarial Support

The Sub-Committee Secretary shall be determined by the Lead Director.

11. Review Date

These terms of reference shall be reviewed on at least an annual basis by the Sub Committee for approval by the *Board/Committee*.

Appendix D

Example Capital Highlight Reporting Process

As part of a continuous improvement of capital governance and reporting structures, this reporting process has been developed to ensure that a timely and consistent capital project reporting mechanism is in place for each Project Director on behalf of Project Groups to report on project progress.

The process is outlined as follows:

Individual capital highlight project report templates, in Powerpoint slide format, are developed by Project Managers to provide a progress update and are reviewed by the Project Director and Senior Responsible Officer on the scheme before being submitted to the Capital Planning Team.

In the case where projects are led by other organisations, the capital highlight report is developed by the Project Manager from the lead organisation and reviewed by the Health Board Project Lead, Project Director and Senior Responsible Officer on the scheme before being submitted to the Capital Planning Team.

Detail is included in the highlight reports to enable the Sub Committee to note the bimonthly RAG rating of all capital projects.

This tracker includes updates on all major capital new and existing projects as follows:

- Projects in construction phase
- Projects at business case stage
- Projects at feasibility stage
- Projects at post project evaluation stage

The Capital Planning team collate the reports, develop the Capital Governance Report and include the individual capital highlight reports as an appendix to the paper.

The Capital Governance Report is presented to the Capital Sub Committee on a bi-monthly basis and where necessary by exception to the Strategic Development and Operational Delivery Planning Committee (SD&ODC).

Progress on smaller projects funded through the UHB discretionary capital programme are managed through the Capital Monitoring Forum.

The Capital Governance Report provides a summary of the status of the capital projects, with specific reference to projects reporting a red (Alert) or amber (Advise) RAG status. This report is accompanied by:

Addendum 1 – Assurance Definitions (RAG Ratings)

Addendum 2 – Bi-monthly RAG tracker listing all the Capital Projects, the appointed Senior Responsible Owner and Project Director. The RAG status for each project is reflected via a current rating, reflecting the project's position within the reporting cycle, the definition of which includes:

Addendum 3 – Capital Highlight Reports (single slide format)

A summary update report on capital schemes is submitted to *Board/Committee* at the bi-monthly meetings of the Committee.

Addendum 1 – Assurance Level Definitions (RAG Ratings)

Definitions	
Assurance Level	
Assurance Level: High = **ASSURE**	Project Group wish to assure members of the Capital Sub Committee that the scheme: <u>To be green/assure</u> • The project is generally on track, within agreed budget and timeline and there are no major risks/issues of concern that require escalation. • Actions are robust and effectively addressing any issues. • There are no significant concerns and performance is consistently on target. • Risks are managed effectively with appropriate mitigation <u>For the highlight report:</u> • Provide details of the key 3 or 4 matters you wish the CSC to be **assured of** • Include a brief description of planned activities that have been completed successfully.
Assurance Level: Moderate = **ADVISE**	Project Group wish to advise members of the Capital Sub Committee that the scheme: <u>To be amber/advise</u> • The project or programme is within agreed budget, however there is concern over risks and issues which may affect programme and/or cashflow. • Planned activities are on track / completed successfully, but risks / issues of concern are apparent that require noting to the sub-committee. Mitigation should be place for these risks / issues. • Actions are in place but require close monitoring and additional efforts. <u>The highlight report should</u> • Provide details of the key 3 or 4 matters you wish the CSC to be **advised of**. • Include a brief description of the matter and what you would like the CSC to do. • Include a brief description of planned activities that are on track / completed successfully, but risks / issues of concern are apparent that require noting to the sub-committee. Mitigation should be place for these risks / issues.

Assurance Level: Low = **ALERT**	Project Group wish to alert members of the Capital Sub Committee that the scheme: To be red/alert: Project is delayed/overrun, outturn exceeds the agreed budget, significant risks / issues not mitigated. • Planned key milestones/activities not achieved during this period and no mitigation in place to achieve next period. • Actions are insufficient or not effectively addressing the issue. • Significant concerns exist, and there is a high risk of not meeting target For highlight report should: • Provide details of the key 3 or 4 matters you wish the CSC to be **alerted** to. • Include brief description of the matter and what you would like the CSC to do. i.e. where planned key milestones / activities have not been achieved during this period and no mitigation in place to achieve in next period.

Addendum 2 - Capital Project – Bi-Monthly Risk Assessment Tracker

PROJECT	PROJECT VALUE	SRO/ Project Director	RAG Indicator											
Month			ALERT, ADVISE or ASSURE	June 24	July 24	Sept 24	Nov 24	Jan 25	March 25	May 25	July 25	Sept 25	Nov 25	Jan 26
Projects led by Health Board														
				No report required	No report required	No report required	No report required							
											No report required	No report required	No report required	No report required
				No report required	No report required	No report required	No report required							
Projects led by other organisations														
				On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold	On hold
												No report required	No report required	No report required

Addendum 3 - Capital Highlight Reports (Slide Format)

SRO	Stage	Author: PM/PD
PD	Next key milestone	

Project A

Project Description

Current RAG	ASSURE ADVISE ALERT

SOC		OBC		BJC		Construction		Commissioning		Total Value of Scheme	

Activities Completed	Activities Planned	Matters for sub-committee attention
		UHB Risks Risks / Mitigating Actions
		UHB Issues
UHB Comments		

Appendix E

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

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

Public Sector Internal Audit Standards

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

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Speaking Up Safely

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-25
Fieldwork	January - February 2026
Executive Sign Off	April 2026
Audit Committee	June 2026
Executive Lead	Debbie Eyitayo, Executive Director of People Services & OD
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Ossama Lotfy, Principal Auditor

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the arrangements in place for staff to raise concerns through the Speaking Up Safely process, and how these are reviewed, resolved and reported.

Overview

The Speaking Up Safely (SUS) process is accessible but lacks effective oversight, timely case management, and sufficient feedback mechanisms to provide assurance that concerns are being resolved safely and in line with national and statutory requirements. A process change review, approved in December 2025, was undertaken to ensure alignment with the national framework, however the revised arrangements have not yet been embedded or evaluated, and assurance over their effectiveness cannot yet be demonstrated.

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

- Local SUS policies, procedures and guidance are in place but are not yet fully aligned with the national Welsh Government Speaking Up Safely Framework, and the approved process changes have not yet been implemented or embedded.
- The combination of prolonged case durations and limited capture of staff feedback reduces the Health Board's ability to confirm effective resolution of concerns and embed organisational learning.
- The Health Board cannot demonstrate compliance with training requirements set out in the Welsh Government Speaking Up Safely Framework as there is no consistent monitoring or reporting of completion or refresher training for staff and managers.
- Although SUS information is routinely included within the People Services and OD Overview Update Report to the Local Partnership Forum (LPF), there is no further assurance reporting to the People & Culture Committee (P&C), or evidence of meaningful scrutiny or discussion by either the LPF or the P&C Committee.
- Management reported very low engagement with the *Working in Confidence* platform evaluation function during 2025, significantly limiting insight into staff experience of the SUS process. At the same time, management confirmed they cannot evidence compliance with Section 47B of the Public Interest Disclosure Act (PIDA) 1998, which protects staff from detriment after raising a concern.

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

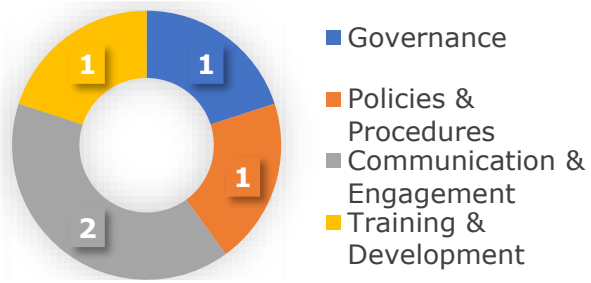
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The process for staff to raise concerns is clearly documented and subject to regular review.	1	**Reasonable**
2	Staff are aware of the process for raising a concern, and can do so with confidence that they will be fully supported and not suffer detriment as a result.	2	**Limited**
3	Designated contacts responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately.	3	**Limited**
4	Concerns raised by staff are monitored, reviewed and analysed to identify recurring themes or trends, with issues escalated as appropriate.	4,5	**Limited**

Management Actions

4	1
High Priority	Medium Priority

Themes



Risk Types

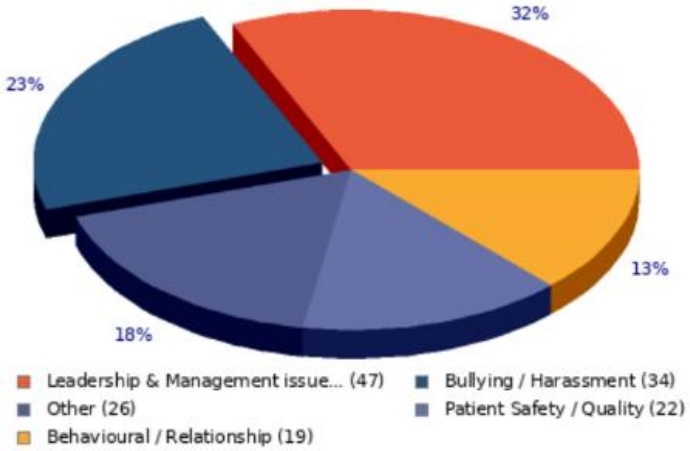
Legal & Regulatory Non-Compliance

Speaking Up Safely - At a Glance

Extract from the Work In Confidence report[1] (1 April 2024 – 31 December 2025) summarises the conversations stated by Category for Speaking Up Safely:

Categories

Your Top 5 Categories



Conversations Started by Category

Category	Number Received
Leadership & Management issue...	47
Bullying / Harassment	34
Other	26
Patient Safety / Quality	22
Behavioural / Relationship	19
Staff Safety	15
Equality, Diversity & Inclusio...	13
System / Process	7
Sexual Safety	1
Total	**184**

Note: Any categories marked as "Inactive" means that they have been removed from the system.

[1] Work In Confidence Conversation Report 2026 for Betsi Cadwaladr University Health Board for the period 01/01/2024 to 31/12/2025 (provided by Health Board)

Findings & Agreed Action Plan

Objective 1: The process for staff to raise concerns is clearly documented and subject to regular review.	**Reasonable**

The Health Board has established a dedicated Speaking Up Safely (SUS) webpage on BetsiNet, which signposts staff to a range of reporting routes, including an external anonymous reporting platform, a dedicated inbox, and direct contact details for the SUS Guardian and multidisciplinary team. Management advise that the reporting process is clearly documented and accessible, with approximately 2% of staff registered on the anonymous platform. Additional measures are in place to support accessibility, including posters with QR codes and contact details for staff with limited IT access, and a small cohort of SUS Champions embedded within services to act as local advocates.

Key All-Wales policies, including *WP4a – Procedure for Staff to Raise Concerns*, *WP84 – Upholding Professional Standards in Wales*, and *WP5 – Respect and Resolution Policy*, are approved through appropriate governance routes and available bilingually. However, the audit identified that existing local procedures and guidance do not consistently reflect the requirements of the national SUS Framework, published in 2023. In particular, prior to a recent review, there was limited clarity around the Guardian's role, referral pathways, and arrangements for recording and monitoring concerns.

A process change review, approved in December 2025, was undertaken to address these gaps and improve alignment with the national framework. An implementation plan has been agreed, covering communication, platform development, mailbox arrangements, and evaluation reporting, with oversight through the People & Culture Committee. As the review was only recently approved, the revised arrangements have not yet been embedded or evaluated.

Management also acknowledged inherent limitations in data collection due to the need to protect anonymity, which may continue to restrict the Health Board's ability to fully assess staff experience and outcomes.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Policies and Procedures** Local Speaking Up Safely policies, procedures and guidance are not yet fully aligned with the national Welsh Government Speaking Up Safely Framework, which was published in 2023, and the approved process changes have not yet been implemented or embedded.	There is a risk that continued misalignment with the national framework may result in inconsistent handling of concerns, reduced staff confidence in the process, and limited assurance to the Board that concerns are managed in line	**Agreed Actions:** The agreed actions address the lack of alignment between local Speaking Up Safely policies and procedures and the Welsh Government Speaking Up Safely Framework, which limits assurance that concerns are managed consistently and in line with national expectations. 1. Update and align the Speaking Up Safely policy, procedures and guidance with the Welsh Government Speaking Up Safely Framework. 2. Evidence compliance through a documented policy-to-framework mapping exercise. 3. Confirm and publish clear referral and escalation pathways and defined roles and responsibilities. 4. Implement proportionate monitoring arrangements with agreed metrics to support oversight and assurance.

		with national expectations.	5. Embed routine reporting to Executive Team and relevant Committees in line with SUS Framework governance requirements. 6. Capture and triangulate learning from Speaking Up Safely cases to inform organisational learning and improvement. 7. Communicate and embed arrangements across the organisation via staff communications and leadership engagement. 8. Review arrangements annually to ensure continued alignment with WG guidance and organisational learning. Implementation of these actions will support consistent handling of concerns, improve staff confidence in Speaking Up Safely arrangements, and provide clearer assurance to the Board of compliance with the Welsh Government framework.
			Expected Evidence of Implementation: Speaking Up Safely policy, procedures and guidance that fully align with the Welsh Government Speaking Up Safely Framework, ensuring clear referral pathways, defined roles and responsibilities, and proportionate monitoring and reporting arrangements.
		Medium Priority	**Officer:** Head Of Organisational Development Speaking Up Safely Lead Guardian **Target Implementation Date:** 31 October 2026
	Theme: Policies & Procedures	Control Design	

Objective 2: Staff are aware of the process for raising a concern, and can do so with confidence that they will be fully supported and not suffer detriment as a result.	**Limited**

Speaking Up Safely (SUS) arrangements are established and accessible through multiple routes, including Datix, line managers, People Services (Workforce), colleagues, Trade Union representatives, and the Working in Confidence anonymous platform. As noted above, several measures are in place to support accessibility, including posters and SUS Champions.

Concerns are logged within the Working in Confidence platform and are accessible only to the SUS Multi-Disciplinary Team (MDT) or Guardian and the staff member raising the concern, supporting confidentiality.

The NHS Wales Speaking up safely framework (Autumn 2023) requires that cases are closed, and outcomes communicated to staff within twenty-eight (28) days. Management information indicates that between 1 January 2024 and 31 December 2025, two hundred and fifty-three (253)

concerns were raised and logged within the Working in Confidence platform. However, average time to close cases as of 31 December 2025 was sixty-five (65) days, significantly exceeding the national target of 28 days.

We reviewed fifteen (15) cases; whilst there was evidence of proactive engagement by the Lead Guardian and management during the case lifecycle, seven (7) cases (47%) exceeded the twenty-eight (28) day target, with closure times ranging from thirty-four (34) to one hundred and fifty-two (152) days. Extended case durations were observed across a range of themes, including leadership and management, bullying and harassment, and sexual safety.

A significant issue identified through our review of information was the absence of recorded staff feedback following case closure. In thirteen (13) of the fifteen (15) cases reviewed (87%), there was no documented evidence that staff members had confirmed whether their concern had been resolved to their satisfaction, although we do note this is often due to staff members not responding.

In the absence of staff feedback, cases might be closed administratively rather than concluded substantively. Closure does not always equate to resolution, and this limits assurance that underlying cultural, behavioural, or safety concerns have been fully addressed.

The NHS Wales Staff Survey (2024) indicated that for the theme of 'speaking up', and sub-theme of 'raising concerns', 57.8% of that staff who completed the survey answered positively, which is an increase in the previous year (56%), but below the NHS Wales average of 60.7%.

Improving oversight of cases exceeding twenty-eight (28) days and ensuring systematic capture of staff feedback is critical to improving assurance, staff confidence, and learning from concerns raised.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Prolonged Case Durations & Limited Capture of Staff Feedback** Speaking Up Safely case closure does not consistently demonstrate that concerns have been resolved to staff members' satisfaction. In the sample of 15 cases reviewed, 13 cases (87%) had no recorded staff feedback following closure, and seven cases (47%) exceeded the 28-day target for communicating outcomes. Average time to close cases as of 31 December 2025 was 65 days, significantly exceeding the national target of 28 days. The combination of prolonged case durations and limited capture of staff feedback reduces the organisation's ability to confirm effective resolution and embed organisational learning. While evidence of engagement and commitment to the Speaking Up Safely process was observed, overall assurance is reduced.	The absence of timely case closure and documented staff feedback creates a risk that concerns are reported as closed without confirmation of effective resolution. This reduces organisational assurance, constrains learning from concerns raised, and increases the likelihood that unresolved issues persist or re-emerge. Over time, this may	**Agreed Action:** The actions below address prolonged Speaking Up Safely case durations and the limited capture of staff feedback, which reduce assurance that concerns are resolved effectively, within national timescales, and to the satisfaction of those raising them. 1. Agree and approve documented Speaking Up Safely case-closure criteria through the People & Culture Delivery Group. 2. Define resolution standards, clearly distinguishing substantive resolution from administrative closure. 3. Set minimum mandatory actions required prior to case closure, including documentation and decision sign-off. 4. Specify escalation triggers, including circumstances requiring extended timescales or senior review. 5. Embed mandatory staff feedback as a prerequisite to case closure. 6. Define escalation routes for cases exceeding the 28-day national target, with clear accountability. 7. Implement reporting to monitor case duration against the 28-day target.

		undermine staff confidence in the Speaking Up Safely process.	8. Identify and escalate overdue or complex cases through routine performance reporting. 9. Undertake trend analysis of prolonged cases and recurring causes of delay to inform service improvement. 10. Provide regular assurance reporting to Executive Team via People and Culture Delivery group and relevant Committee. Collectively, these actions will strengthen assurance over timely case resolution, improve confirmation of effective outcomes, and support organisational learning while maintaining staff confidence in the Speaking Up Safely process.
			Expected Evidence of Implementation: Documented Speaking Up Safely case-closure criteria, approved by the appropriate governance group, clearly defining: ▪ What constitutes "resolution" (as distinct from administrative closure). ▪ Minimum actions required before a case can be closed. ▪ Circumstances that require escalation or extended timescales. ▪ Mandatory steps for seeking staff feedback prior to closure. ▪ Defined escalation routes for cases exceeding the 28-day national target. ▪ Management information and performance reports demonstrate monitoring of case duration against the 28-day target; identification and escalation of overdue or complex cases; and trend analysis of prolonged cases and common causes of delay.
		High Priority	**Officer:** Head Of Organisational Development Speaking Up Safely Lead Guardian **Target Implementation Date:** 31 October 2026
	Theme: Communication & Engagement	Control Design	

Objective 3: Designated contacts responsible for the handling of staff concerns are aware of their responsibilities and have received adequate training to deal with the concerns appropriately.	**Limited**

The Health Board has established multiple routes through which staff can raise concerns and access advice, guidance, and wellbeing support. These routes include Occupational Health and Wellbeing, People Services and Organisational Development, Trade Unions, line management, and centrally available resources such as the Living Well, Working Well Handbook. In addition, all staff are required to complete a corporate induction programme, which provides an overview of organisational values, processes, and routes for raising concerns, including Speaking Up Safely, supporting early awareness for new starters.

Extracts from the Speaking Up Safely Framework for the NHS in Wales highlight the organisation's responsibility to ensure that individuals responding to concerns, particularly managers, are appropriately trained and supported. The framework also requires organisations to ensure

that suitable training is delivered across leaders, managers, and staff as part of leadership and management development arrangements. At present, the Health Board is unable to demonstrate compliance with these requirements.

Management confirmed that a range of training is available to support a Speaking up culture, including All Wales Duty of Candour training and "Listen Up" training for managers. Duty of Candour training supports statutory requirements introduced from April 2023, while the Listen Up programme focuses on creating environments that encourage speaking up, promote effective listening, and address barriers to raising concerns.

However, while training provision exists, the audit identified limitations in the Health Board's ability to evidence compliance with training expectations. Speaking Up Safely and Duty of Candour training are not currently mandated and, as a result, management is unable to produce comprehensive compliance figures. In addition, refresher training requirements are not clearly defined, and completion rates are not routinely monitored or reported.

Key Findings		Risk & Impact	Agreed Management Action
3	**Training** The Health Board cannot demonstrate compliance with Speaking Up Safely training requirements. Training is not mandated, and there is no consistent monitoring or reporting of completion or refresher training for staff and managers. This position is not aligned with the Speaking Up Safely Framework for the NHS in Wales, which states an organisations requirement to *'Ensure that appropriate training to deliver a Speaking Up Safely culture is rolled out to leaders, managers and staff throughout the organisation, as part of leadership and management development arrangements'*. As a result, the Health Board cannot provide assurance that staff and managers—particularly those responsible for receiving and responding to concerns—have received appropriate and timely training.	Increased risk that concerns are not escalated or are poorly managed. The Board lacks assurance that organisational practice aligns with the Speaking Up Safely Framework for the NHS in Wales.	**Agreed Action**: The agreed actions below address the lack of Speaking Up Safely training and associated monitoring arrangements, which limits assurance that staff and managers are equipped to manage concerns effectively and increases the risk of misalignment with the Speaking Up Safely Framework for the NHS in Wales. 1. Develop and approve a workforce training framework setting out mandatory Speaking Up Safely and Duty of Candour training requirements for all staff involved in managing concerns. 2. Define target staff groups and roles, including minimum training standards and responsibilities. 3. Implement compliance monitoring, with routine reports showing training completion rates across staff groups. 4. Establish refresher training cycles to maintain ongoing competence and compliance. 5. Produce information to provide assurance on training uptake, compliance trends and gaps. 6. Embed Board/Delivery Group/Committee oversight through regular reporting and escalation where compliance falls below agreed thresholds. Implementation of these actions will provide improved assurance to the Board that Speaking Up Safely training arrangements are compliant with the NHS Wales framework and support the effective management and escalation of concerns. **Expected Evidence of Implementation:**

			▪ An approved training framework confirming mandatory Speaking Up Safely and Duty of Candour training requirements for those dealing with concerns. ▪ Compliance reports showing completion rates across staff groups. ▪ Defined refresher training cycles; and management information demonstrating oversight at Board or committee level.
		High Priority	**Officer:** Head Of Organisational Development Speaking Up Safely Lead Guardian **Target Implementation Date:** 31 January 2027
	Theme: Training & Development	Control Design	

Objective 4: Concerns raised by staff are monitored, reviewed and analysed to identify recurring themes or trends, with issues escalated as appropriate. **Limited**

Speaking Up Safely is included within the People Services and Organisational Development (OD) Overview Update, which includes data on concerns received, categories and trends, as well as other relevant information, such as recruitment and learning. This report is presented to the Local Partnership Forum (LPF) which has defined responsibilities for workforce governance, employee relations, and assurance relating to staff concerns.

The LPF, as outlined in its Terms of Reference (TOR), is the formal mechanism enabling management and staff organisations to work together on workforce and health service priorities. It meets quarterly and has established links to the Board through Executive members and regular communication between the Board Chair and LPF Joint Chairs. Despite these structures, review of LPF minutes for February, August, and December 2025 found no documented discussion of Speaking Up Safely and no related actions recorded in the LPF action log. This indicates limited evidence of active engagement with, or oversight of the Speaking Up Safely process.

The People & Culture Committee's TOR require it to provide assurance to the Board on compliance with legislation, guidance and best practice across the People and OD agenda, including explicit delegated responsibility for whistleblowing and Speaking Up Safely. However, review of Committee papers and minutes for June, August, October and December 2025 similarly found no detailed information or discussions on Speaking Up Safely and no actions recorded in its action log, despite its formal oversight role.

Management reported that the Working in Confidence platform enables two-way communication with individuals raising concerns and provides an evaluation option once a case is closed; however, staff engagement with this feature during 2025 was very low (16 responses from 111 closed conversations), limiting the Health Board's ability to gather meaningful feedback on user experience. Management also advised that they are unable to evidence compliance with Section 47B of the Public Interest Disclosure Act (PIDA) 1998, which protects workers from detriment following a protected disclosure. Although the WP4a *"Procedure for Staff to Raise Concerns"* clearly outlines these legal protections, the low level of staff feedback means the Health Board is unable to demonstrate compliance in practice, as there is no reliable monitoring or assurance mechanism to evidence that these protections are being applied.

Key Findings		Risk & Impact	Agreed Management Action
4	**Lack of Documented Oversight of Speaking Up Safely by LPF and P&C Committee** Although Speaking Up Safely is routinely included within the People Services and OD Overview Update Report to the LPF, there is no evidence of meaningful scrutiny or discussion by the LPF. The report to the People & Culture Committee does not include information on Speaking Up Safely. Reviews of meeting minutes and action logs across 2025 showed no recorded debate, challenge, or actions relating to Speaking Up Safely, despite both groups having explicit responsibilities for workforce governance, employee relations and whistleblowing assurance.	Without clear oversight, there is reduced visibility of staff concerns, limited assurance on whether emerging risks are being identified or addressed and missed opportunities to strengthen organisational culture and staff confidence in raising concerns.	**Agreed Actions:** The agreed actions below are intended to address the lack of documented oversight and assurance of Speaking Up Safely at the Local Partnership Forum and the People & Culture Committee, and to strengthen governance arrangements in line with their workforce and whistleblowing responsibilities. 1. Embed Speaking Up Safely as a standing item at the Local Partnership Forum, with routine reporting and documented discussion. 2. Include Speaking Up Safely assurance as a standing section in the People Operations Report to the People & Culture Committee. 3. Ensure governance minutes and action logs evidence scrutiny, challenge and decisions relating to Speaking Up Safely. These actions directly address the absence of documented scrutiny and assurance, increasing visibility of staff concerns and strengthening confidence that emerging risks are identified, challenged and addressed through appropriate governance arrangements.
			Expected Evidence of Implementation: Evidence that Speaking Up Safely metrics and outcome data is considered regularly at the Local Partnership Forum. Speaking Up Safely assurance is included as a standing item in the People Operations Report presented to the People & Culture Committee.
		High Priority	**Officer:** Head Of Organisational Development Speaking Up Safely Lead Guardian **Target Implementation Date:** 31 August 2026
	Theme: Governance	Control Operation	
5	**Inability to Demonstrate Compliance with Public Interest Disclosure Act and Low Staff Feedback** Management reported very low engagement with the *Working in Confidence* platform's evaluation function during 2025, significantly limiting insight into staff experience of the	Staff may experience detriment without detection, exposing the organisation to	**Agreed Actions:** The agreed actions address the lack of assurance over compliance with the Public Interest Disclosure Act (PIDA) 1998 and the limited insight into staff experience arising from the fully anonymous nature of the Speaking Up Safely platform, which restricts the

	Speaking Up Safely process. At the same time, management confirmed they cannot evidence compliance with Section 47B of the Public Interest Disclosure Act (PIDA) 1998, which protects staff from detriment after raising a concern. Although the organisation's WP4a procedure clearly outlines these protections, the low level of staff feedback prevents meaningful assessment of whether these protections are being upheld in practice. Additionally, the organisation lacks a systematic monitoring or assurance mechanism to track potential detriment, limiting its ability to identify patterns, intervene early, or provide assurance to governance forums.	legal and reputational consequences. Low confidence in Speaking Up Safely may discourage staff from raising concerns, reducing organisational learning and safety.	organisation's ability to identify potential detriment and assess whether protections are effective in practice. 1. Define and implement a proportionate assurance framework for PIDA compliance, setting out how protection from detriment will be monitored and evidenced within the constraints of an anonymous reporting system. 2. Strengthen encouragement of voluntary staff feedback within the Speaking Up Safely platform, clearly communicating the value of feedback while recognising that responses cannot be mandated. 3. Improve management information derived from available platform data, including case progression, timeliness, themes, and repeat concern indicators, to support proxy assurance where direct feedback is not available. 4. Establish alternative assurance mechanisms to identify potential detriment, such as triangulation with workforce data, employee relations activity, grievances, and staff survey intelligence. 5. Define escalation triggers and review arrangements where indicators suggest potential detriment, repeat concerns, or reduced confidence in the Speaking Up Safely process. 6. Implement routine reporting to the Executive Team and relevant Committees on PIDA assurance, feedback levels, potential detriment indicators, and mitigating actions. Combined, these actions will strengthen assurance of PIDA compliance and protection from detriment, while recognising the limitations of a fully anonymous system and improving confidence in the Speaking Up Safely arrangements.
			Expected Evidence of Implementation: Management information evidence systematic monitoring of potential detriment following protected disclosures, use of the Working in Confidence evaluation function, and documented follow-up where feedback is not provided.
		High Priority	**Officer:** Head Of Organisational Development Speaking Up Safely Lead Guardian **Target Implementation Date:** 31 December 2026
	Theme: Communication & Engagement	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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Shared Services Partnership
Audit and Assurance Services

Planned Care Major Change Programme – Governance and Delivery

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-19
Fieldwork	January - March 2026
Executive Sign Off	23 April 2026
Audit Committee	June 2026
Executive Lead	Tehmeena Ajmal, Chief Operating Officer / Senior Responsible Owner
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit Rhys Jones, Principal Auditor

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the effectiveness of established processes and governance arrangements to support delivery of the Planned Care Major Change Programme.

Overview

The Health Board has established formal processes, systems, and governance arrangements to manage and support delivery of the Planned Care Major Change Programme. While progress has been made across all projects, delivery has not been consistently achieved within agreed timescales. We recognise that implementation is influenced by the engagement and availability of key clinical and operational staff, as well as the progress and impact of interdependent local and national programmes. However, as outlined in the Project Initiation Document, ultimate accountability for successful delivery rests with the Programme Leadership Team.

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

- There is currently no formal mechanism for routine reporting and escalation from the Planned Care Programme Board to the Executive Committee, as required by the Board's Terms of Reference.
- Projects and initiatives have progressed, but delivery has not been consistently achieved within the planned timescales.
- The lead responsible for Workstreams 3 and 5 left the Health Board in December 2025 and has not been replaced, resulting in a leadership gap that may impact timely delivery of enabling actions.
- While the updates show progress across most projects, the level of advancement varies by workstream, and the current completion rates indicate that the programme is unlikely to achieve all planned delivery milestones within the expected timeframe. Of the twelve projects planned for completion by January 2026, only two were delivered, with nine rolled forward to quarter four.
- The Board and its Committees have not been routinely sighted on delivery progress. Limited detailed workstream updates, assurance, and escalation of issues affecting delivery have been provided throughout the year.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. We also noted the Project Initiation Document (PID), although comprehensive, was developed retrospectively and was only formally endorsed by the Planned Care Major Change Programme Board at its meeting on 23 February 2026. We have not raised a finding relating to this as it is now approved.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is appropriate governance in place for the Programme and workstreams, including documented objectives/outcomes, and clear roles and responsibilities in relation to delivery and decision making. We will consider whether key decisions made are in line with the governance structure / Scheme of Reservation and Delegation (where relevant).	1	**Reasonable**
2	There are effective controls in place to manage delivery within each workstream, i.e. progress reviews, resource reviews, delivery against objectives. We will consider the evidence and data available to support delivery.	2, 3	**Limited**
3	There is reporting to the Board on performance of the workstreams / Programme and delivery of outcomes/improvements.	4	**Limited**

Management Actions

4	0
High Priority	Medium Priority

Themes

Risk Types

Quality or Safety Issues

Choose an item.

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: There is appropriate governance in place for the Programme and workstreams, including documented objectives/outcomes, and clear roles and responsibilities in relation to delivery and decision making. We will consider whether key decisions made are in line with the governance structure / Scheme of Reservation and Delegation (where relevant).	**Reasonable**

Timely access to planned care and cancer pathways is a core priority for the Health Board and forms part of its wider commitment to improving services for the population of North Wales. Persistent challenges in these areas led to Planned Care being formally incorporated into the Health Board's portfolio of Major Change Programmes in June 2025 to support significant and accelerated improvement. The Programme is structured around six Workstreams aligned with the Health Board's Integrated Medium-Term Plan (2025–28), the 2025–26 Delivery Priorities, and Ministerial Enabling Actions.

A formal Project Initiation Document (PID) underpins the Programme by defining its aims, scope, objectives, governance arrangements, and key roles and responsibilities. While comprehensive, the PID was developed retrospectively and was only recently endorsed at the Programme Board meeting on 23 February 2026. This issue has not been included in the findings table as the PID has now been approved. However, the retrospective development and delayed approval of the PID increased the risk of the Programme progressing without a clearly defined scope, governance structure, or roles and responsibilities, potentially leading to inconsistent application of programme controls.

Governance is centred on the Planned Care Major Change Programme Board, which provides oversight, strategic direction, and risk monitoring. The Board meets every six weeks, although the January 2026 meeting was cancelled, and is chaired by the Programme Senior Responsible Owner (the Health Board Chief Executive Officer). The Terms of Reference specify that the Board should report formally to the Executive Committee and provide monthly updates to the Portfolio Office; however, routine reporting and escalation arrangements to the Executive Committee have not been formally established.

Review of documentation from four recent Programme Board meetings confirmed consistent standing agenda items, including programme updates, highlight reports, cost pressures, risks, and action tracking. Workstream reviews are included as agenda items, although not all Workstreams are discussed at every meeting. All minutes, papers, and reports requested were provided for review, and no issues of significance were noted. The Programme Board does not hold delegated financial authority and escalates financial matters to the Executive Committee for consideration as part of the wider IMTP financial planning process.

Additional supporting structures include the newly formed Planned Care Clinical Group (established January 2026) and the Programme Risk Sub-Group. Operationally, Project Team meetings take place every six weeks, during which Workstream leads present Highlight Reports for scrutiny and discussion ahead of Programme Board submission. The Programme Director and Programme Manager reported that they also meet Workstream leads frequently, sometimes weekly, depending on operational need.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Reporting to Executive Committee** Routine reporting and escalation arrangements from the Planned Care Programme Board to the Executive Committee have not been formally established, despite this requirement being set out in the Programme Board's Terms of Reference.	Senior leadership is not appropriately informed of programme progress or emerging issues,	**Agreed Action:** (1-1) Following every Planned Care Programme Board, submit the AAA report to the Executive Committee, to be supplemented with a copy of the Programme Highlight Report that the Programme Board reviewed, in order to provide more detail if required

	The Programme Director confirmed that the Programme Board has not provided formal progress updates or assurance to the Executive Committee to date, although a detailed 'deep dive' update is planned for presentation in March 2026.	potentially weakening strategic oversight and timely decision-making.	(1-2) Undertake a Deep Dive of the Programme at the Informal Executive Group on a rolling programme across the Major Change Programmes (Planned Care Programme last presented March 2026)
			Expected Evidence of Implementation: Routine formal reporting and escalation from Programme Board to Executive Committee per Programme Board Terms of Reference.
		High Priority	**Officer:** Planned Care Programme Director **Target Implementation Date:** 31st May 2026
	Theme: Reporting	Control Operation	

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**

The Programme has established appropriate formal controls, including routine progress monitoring and active engagement with Workstream and project leads. However, these controls have not consistently resulted in projects and initiatives being delivered within their intended timescales.

Programme delivery is managed internally through a real-time, Excel-based Programme Plan tracker, maintained by the Programme Director and Programme Manager. The tracker records project progress, risks, issues, decisions, cost pressures, and benefits, and is used to inform reporting to the Programme Board and the portal.

The Programme consists of eighteen delivery priorities across six Workstreams, broken down into twenty-seven individual 2025–26 projects and initiatives. We confirmed that five of the six Workstreams have named leads; however, the lead for Workstreams 3 and 5 left the Health Board in December 2025, creating a leadership gap that may delay delivery of enabling actions. We confirmed that this has been recorded in the Programme Issue Log. Workstream 6 is overseen by a collaborative group of subject matter experts rather than a single designated lead.

A review of the Programme Plan tracker (January 2026 data) confirmed that it was well maintained, with updates provided for all but one Workstream 6 project, where an update had been requested. Issues affecting project or initiative progress were appropriately logged. While supporting evidence is not routinely submitted to validate updates, the Programme Director reported confidence in their accuracy due to close involvement in project activity. The Programme Director also advised that the updates are intended solely for internal management use and are not subject to wider reporting. A sample review of five projects confirmed consistency between tracker updates and supporting evidence.

Project completion timescales are expressed as planned quarter delivery. By January 2026, twelve projects were expected to be completed; however, only two had been finalised, with nine carried forward to Quarter 4. A confidence rating is assigned to each project or initiative. Ratings varied across outstanding projects, and eight were already planned for carryover into 2026–27. While progress is evident across most projects, delivery levels vary by Workstream and fall short of planned expectations.

Key Findings		Risk & Impact	Agreed Management Action
2	**Project Delivery** Projects and initiatives have progressed, but delivery has not been consistently achieved within the planned timescales. Of the twelve projects planned for completion by January 2026, only two were delivered, with nine rolled forward to quarter four. Delivery data presented in the February 2026 Highlight Report showed a slight improvement in performance; however, overall delivery remained below planned expectations.	Failure to deliver Planned Care Major Change Programme within the planned timescales resulting in an adverse impact on patient safety and expected delivery.	**Agreed Action:** (2-1) Undertake full engagement with the Planned Care Programme Board members on the priorities for inclusion in the 2026/27 plan, aligned to the refreshed IMTP (published April 2026), committing to only those activities that have secure funding and resources to ensure delivery; set out in the project tracker with clear milestones and delivery dates for reporting via the Highlight reports, T&I Performance portal and AAA reports. **Expected Evidence of Implementation:** Improved delivery performance across the programme. Key milestones being met within planned timescales.
		High Priority	**Officer:** Planned Care Programme Director **Target Implementation Date:** Finalised 31st May 2026
	Theme: Planning, Delivery & Deadline Management	Control Operation	
3	**Workstream Leads** We confirmed that five of the six workstreams have named leads. Workstream 6 is overseen by a collaborative group of subject matter experts rather than a single lead. However, the lead responsible for Workstreams 3 and 5 left the organisation in December 2025, resulting in a leadership gap that may impact timely delivery of enabling actions.	The gap in leadership could impact delivery of enabling actions / projects.	**Agreed Action:** (3-1) Identification of Workstream Leads for 3 and 5 relevant to the workstream aim and content; with a co, or deputy lead identified to mitigate the risk of loss of leadership. **Expected Evidence of Implementation:** Adequate succession arrangements are in place to mitigate the risk associated with a Workstream / project Lead leaving.
		High Priority	**Officer:** Planned Care Programme Director **Target Implementation Date:** 31st May 2026
	Theme: Resourcing	Control Design	

Objective 3: There is reporting to the Board on performance of the workstreams / Programme and delivery of outcomes/improvements.	**Limited**

Workstream delivery reporting to the Planned Care Major Change Programme Board was found to be robust, as outlined under Objective 1. However, scrutiny of published papers for all 2025–26 Board, Performance, Finance and Information Governance (PFIG) Committee, and Planning, Population Health and Partnerships (PPHP) Committee meetings identified limited detailed reporting on Workstream progress, assurance, or escalation of issues affecting delivery.

Integrated Medium Term Plan (IMTP) priority delivery is reported through the Annual Delivery Plan (ADP) Quarterly Update Reports submitted to the Board, PFIG, and PPHP. The revised format Quarter 1 and Quarter 2 reports provide only high-level information on performance and broad progress by strategic objective and sub-objective. These submissions did not include detailed updates for each individual delivery priority. Although the reports summarised the current position, highlighted areas of focus, and reported a "low" overall delivery confidence rating for Planned Care, they did not present a breakdown of delivery status for each Planned Care priority.

The Quarter 3 ADP Progress Report, presented to PFIG on 24 February 2026, provided a more comprehensive update than earlier submissions. The associated Monitoring Report assigned confidence ratings to each IMTP deliverable, including the eighteen Planned Care priorities, and summarised current progress, key areas of focus for the remainder of the year, and anticipated impact. However, this represents the first point in the financial year at which the Board and its Committees have received this level of detail.

Additional reporting included a Planned Care Delivery 2025–26 paper presented to the July 2025 Board, which outlined ongoing work and early areas of progress, and an update on Theatre Optimisation (Workstream 4) presented to PFIG in October 2025, which also referenced selected Workstream 1 deliverables.

Planned Care performance continues to be routinely monitored through the Integrated Quality and Performance Report (IQPR). However, improvements in reported performance are not directly reconciled to Programme delivery activity. Planned Care is also referenced within the Board Assurance Framework and the Corporate Risk Register.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Board and Committee Reporting** The Board and its Committees have not been routinely sighted on delivery progress. Limited detailed workstream updates, assurance, and escalation of issues affecting delivery have been provided throughout the year. The Quarter 3 ADP Progress Report, presented to PFIG on 24 February 2026, provided a more comprehensive update than earlier submissions. The accompanying Monitoring Report assigned confidence ratings to each IMTP deliverable, including the eighteen Planned Care priorities, and summarised progress, key remaining focus areas, and anticipated impact. However, this was the first point in the financial year at which the Board and its Committees received this level of detail.	Limited routine reporting to the Board and its Committees increases the risk that senior leaders are not fully aware of delivery progress or emerging issues, reducing their ability to provide effective oversight and timely intervention.	**Agreed Action:** (4-1) Implement a quarterly ADP monitoring report for PFIG/PPHP which incorporates: • RAG rating for Delivery Confidence against all priorities within the IMTP • Current position in terms of progress, including constraints to delivery and escalation of issues • An outline of work required for the remainder of the year including any risks to future delivery • A description of the impact achieved through delivery of the priorities

			Expected Evidence of Implementation: Regular, detailed workstream updates, assurance, and escalation of delivery-impacting issues are provided to the Board and its Committees.
		High Priority	**Officer:** Assistant Director Corporate Planning (Interim) / Assistant Director of Transformation and Improvement (Interim) **Target Implementation Date:** 31st May 2026
	Theme: Reporting	Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Executive Committee: Governance

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-05
Fieldwork	February – April 2026
Executive Sign Off	14 May 2026
Audit Committee	June 2026
Executive Lead	Pam Wenger, Director of Corporate Governance
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Effective governance is fundamental to the delivery of safe, high-quality, and sustainable healthcare services across NHS Wales. With increasing service demands and financial pressures, it is essential to have robust governance in place to ensure transparency and responsiveness to key issues within the Health Board.

The purpose of this review was to consider the effectiveness of the Executive Committee and how it is operating. We have not assessed whether the Programme/Project Board or Groups listed in the Executive Committee Terms of Reference, which report to the Executive Committee, are complying with their own Terms of Reference, unless otherwise noted in our detailed findings. We have only reviewed the formal Executive Committee that meets fortnightly; we have not reviewed the informal meeting as we were advised this was used for learning and development.

Overview

We note steps are being taken to revisit the Executive Committee Terms of Reference with the Office of the Director of Corporate Governance advising there are aspects that require refresh.

We have concluded limited assurance on this area, as whilst we recognise that establishing the Executive Committee has increased the openness and transparency of decision making by the Executive, it is not operating in line with the delegated matters set out in its Terms of Reference. The matters requiring management attention include:

- Establishment of the Executive Committee (EC) as a Health Board Committee on 30 January 2025 conflicts with Standing Order 3.4.6; no Executive Director or Local Health Board (LHB) Officer can be appointed as a Health Board Committee Chair. Steps should be taken to formally change the status of the Executive Committee, as a Committee of the Health Board. To ensure the Health Board remains sighted on key decisions delegated to and taken by the Executive, the regular '*Chief Executive Report'* could facilitate this necessary change.
- There is no reporting from the established groups/programmes into the EC, undermining expected governance, control, and assurance reporting. Only the Quality Executive Delivery Group, Risk Scrutiny Group and Policy Oversight Group regularly provide reports.
- We were unable to confirm that all delegated matters set out in the Terms of Reference are being met. A key matter relating to *"Monitor the actions arising from the Integrated Performance Report and performance manage the delivery of those action plans"* could not be evidenced in our review of papers. This was further compounded where no assurance report was forthcoming from the Integrated Performance Executive Delivery Group.
- Our review of papers and minutes from thirteen of fourteen Groups/Programmes scheduled to report into the EC considered matters that should have been considered by the EC, but we were unable to evidence these had been reported to the EC. We did not receive a response to our request for evidence relating to Foundations for the Future Major Change Programme and note this as a breach of Standing Financial Instruction 3.2.2.
- The Chief Executive currently chairs several Groups/Programmes reporting to the EC, though there were limited reports into the Committee evident for these. With a full executive team now established, except for one interim role at the time of review, we believe it beneficial for the Chief Executive to delegate the chairing of Groups/Programmes, to better hold officers accountable for delivery. We further recognise the potential sustainability risks associated with these arrangements, particularly if additional significant matters arise necessitating oversight from the Chief Executive.

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

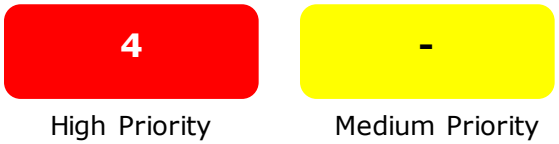
- Details of matters considered and contracts approved at the Executive Committee are reported to the Health Board, including those within the delegated limits of the Executive. Management may wish to consider including the value of decisions taken in awarding contracts in future reports.

Please note: Copilot AI has been used in this review to support analysis of minutes and reports and was operated within the NHS Wales tenancy.

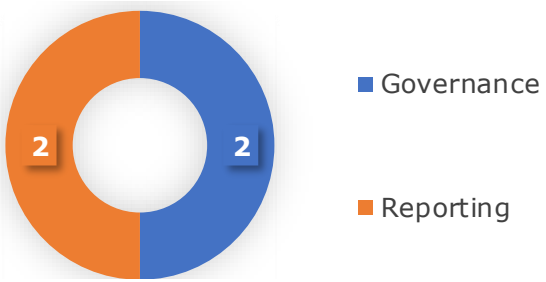
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Executive Committee is operating effectively in line with the delegated powers from the Board, as set out within its Terms of Reference.	1,2	**Limited**
2	The groups that report directly to the Executive Committee are providing regular updates to ensure the Committee is sighted on significant issues and items requiring approval by the Committee and/or escalation.	3,4	**Limited**

Management Actions



Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Executive Committee is operating effectively in line with the delegated powers from the Board, as set out within its Terms of Reference. **Limited**

Overview / Summary of Observations

The Health Board, approved Terms of Reference for the Executive Committee at its meeting on 30 January 2025. Introduction to the Terms of Reference (ToR) state *"The Board shall establish a committee to be known as the Executive Committee. The Executive Committee is the primary executive decision-making body of the Health Board in relation to the delivery of the Health Board's strategic objectives."*

Health Board Standing Orders (SO) are explicit, stipulating how its committees are established. SO 3.4.6 states *"Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers."* The Chair of the Executive Committee (EC) is the Chief Executive and Membership is the Executive and Corporate Directors.

Whilst establishing the EC formalised reporting of issues considered/decisions taken, this should not have been via a Health Board Committee as this conflicts with SO 3.4.6. The Board routinely receive a Chief Executive's Report that could have included key issues considered by the Executive, in line with the delegated powers already invested in the Executive.

We recognise the Director of Corporate Governance and Head of Corporate Office have identified the need to revisit and refresh the current EC ToR. In reviewing the ToR, Agenda and Minutes of the EC, we have identified the following issues:

- Membership details include posts not currently in the Executive and Corporate Director structure.
- There is no defined Vice Chair of the EC but note the Chief Executive delegates responsibility in their absence on an ad-hoc basis.
- There is no cycle of business outlining what items/matters should be brought to the Committee.
- There is no Organogram available documenting the actual Boards/Groups that have been established by the Executive and how the assurance flows into the Executive then to Committees, onwards to the Board.
- The Boards/Groups listed are incomplete or their title has changed e.g. Planning and Transformation Delivery Group is now the Strategic Planning & Service Change Group (Chair - Chief Executive (CEO)). We found new groups having been established and reporting to the EC that are not included in the ToR e.g. Education Steering Group (Chair - CEO) and Mental Health and Learning Disabilities (MHLD) Oversight Delivery Group (Chair - CEO).

With no cycle of business, we reviewed whether the delegated powers within the ToR were met. There are twenty-one specific matters and we reviewed papers presented, noting that some are scheduled around specific times of the financial year e.g. reviewing risk statements in the Annual Governance Statement.

In general, we found that matters were being fulfilled, although we did find some where there was limited on-going consideration e.g. *Oversee the Health Board's compliance with the management of conflicts of interest as stated in the Standing Orders and the Standards of Business Behaviour Policy (delegated matter u)*; we found four specific matters where we could not evidence consideration by the EC during 2025/26:

- *e) Monitor the actions arising from the Integrated Performance Report and performance manage the delivery of those action plans* - no papers are presented for the EC to review performance and there is no report received from the Integrated Performance Executive Delivery Group.
- *f) Approve new and renewal leases in accordance with the Scheme of Reservation and Delegation (SORD) following consideration by the Capital Investment Group* – the Capital Investment Group (CIG) Terms of Reference do not include a delegated matter to approve new or renewal leases; we also found the CIG meetings are consistently not quorate or compliant with its ToR, with it not being chaired by the respective Executive Director.
- *k) Approve policies and procedures in line with the Health Board's overarching policy framework* – responsibility now rests with the Executive Policy Oversight Group with reporting to EC via the Statutory Compliance Report.
- *r) Consider issues arising from Executive Delivery Groups, Governance Groups, and Major Programmes* – with the exception of the Quality Executive Delivery Group, Risk Scrutiny Group, Executive Policy Oversight Group (via the Statutory Compliance Report) and limited reporting from the Strategic Planning and Service Change Group, there was no reporting evident from the remaining Groups/Major Programmes.

For our sample period, we found the reporting from the EC to the Board was complete, with the commercial in confidence decisions reserved for the private Health Board meeting. We did note that some reported decisions, within the delegated limit of the Executive, did not include the amount approved – we have not raised this as an issue and management may wish to consider including the value of decisions taken by the Executive when reporting to the Board.

Key Findings		Risk & Impact	Agreed Management Action
1	**Executive Committee - Standing Order Conflict**		**Agreed Action:**

	The Executive Committee established by the Health Board is not compliant with Standing Order (SO) SO 3.4.6 that states *"Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers"*. As the Chair of the Executive Committee (EC) is the Chief Executive and Membership is the Executive and Corporate Directors it cannot be established as a Health Board Committee.	The Health Board is unable to demonstrate compliance with Standing Orders in the creation of the Executive Committee.	1. Review the Terms of Reference to ensure that it is clear that this is a management committee established by the Chief Executive Officer. 2. The Board will still receive regular reports as part of the transparency and reporting; these will be appended to the CEO from July 2026. **Expected Evidence of Implementation:** The Executive Committee ceases to be a formal Committee of the Board. The decisions taken and matters considered by the Executive are reported as part of routine Executive reports to the Board e.g. via the Chief Executive's Report.
		High Priority	**Officer:** Director of Corporate Governance **Target Implementation Date:** 31 July 2026
	Theme: Governance	Control Operation	
2	**Executive Committee (EC) Terms of Reference (and supporting governance architecture)** Whilst noting the current EC Terms of Reference (ToR) remain extant but are the subject of planned review by the Office of the Director of Corporate Governance; we found the EC is hindered by the lack of reporting for most established groups/programmes, coupled with expected matters that are difficult to evidence achievement. The following key findings were also noted: • ToR are not reflective of the current executive/corporate structure. • There is no cycle of business detailing what is expected at each meeting, allowing for emerging issues with minimum reporting requirements evident. • There is no evidence of performance or finance consideration at the meeting despite this being a specific matter. • A clear organogram detailing all the groups/programmes established by the executive and the flow of reporting and what assurance they provide (identifying those that are not decision making, with reporting then routed via the relevant executive).	The Executive Committee is unable to demonstrate it is delivering on all its delegated matters with a lack of reporting from groups/programmes hindering the flow of assurance through the executive to the Board.	**Agreed Action:** As part of the establishment of reporting groups into the Executive Committee; clear arrangements will be set out including cycle of business and other matters as required in the terms of reference **Expected Evidence of Implementation:** Updated and re-approved EC ToR that reflects current executive structure/membership and a complete and accurate list of reporting groups/programmes with assurance flow. A cycle of business that explicitly maps to EC delegated matters (including scheduled review points for performance, finance, strategic delivery, leases/capital approvals, policy framework, conflicts of interest, etc).
		High Priority	**Officer:** Head of Corporate Business

	Theme: Reporting	Control Operation	**Target Implementation Date:** 31 July 2026

Objective 2: The groups that report directly to the Executive Committee are providing regular updates to ensure the Committee is sighted on significant issues and items requiring approval by the Committee and/or escalation.	**Limited**

Overview / Summary of Observations

The Executive Committee ToR notes fourteen Groups and Major Programmes established and reporting into it; our review of papers presented found this list is incomplete and is not reflective of new Groups having been established since the ToR following approval by the Health Board (see Objective 1 for details).

There is no reporting from these Groups/Programmes into the EC; only the Quality Executive Delivery Group, Risk Scrutiny Group, Executive Policy Oversight Group (via Statutory Compliance Report) report regularly, with limited reporting evident from the Strategic Planning and Service Change Group noted.

We observed the Operational Leadership Team (OLT) reports to the EC, though no other executive senior management group is required to do so.

We contacted the groups requesting evidence and received a reply form all except the Foundations for the Future Major Change Programme – we again must highlight management non-compliance with Standing Financial Instruction 3.2.2.

We reviewed terms of reference, minutes, papers, and agenda to determine whether decisions are escalated to the EC in line with the Scheme of Reservation and Delegation and its Delegated Matters, noting some key issues considered. Our review of the EC papers and minutes were unable to identify reporting of the following issues in line with the set Delegated Matters from the Board:

- OLT (25 November 2025) – agreed in principle to implement standardised catering pricing, recipes, and VAT across all three IHCs from 5 January 2026. We can find no evidence it complies with *Standing Financial Instruction 9.3 Fees and Charges – 9.3.1 "The Executive Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute…"* (Issue of compliance with delegated matter: f).
- Integrated Performance Executive Delivery Group (19 January 2026) – reforecasting the financial position to £17m deficit. We can find no discussion of the financial position within the EC or any reporting from this Delivery Group (Issue of compliance with delegated matter: c).
- Strategic Planning and Service Change Group (13 November 2025) - response to Future Generations Commissioner Recommendations was agreed but has not been considered by the EC. In addition, we cannot find where it has been presented for assurance to a Health Board Committee (Issue of compliance with delegated matter: n).
- Capital Investment Group – all meetings reviewed are not compliant with the ToR (Issue of compliance with delegated matter: f).

The review of some Group terms of reference identified membership often duplicated EC membership e.g. Integrated Performance Executive Delivery Group, Strategic Planning and Service Change Group; this exposes a risk of self-reporting, undermining oversight with no new external scrutiny introduced.

We also noted the Chief Executive is recorded as the chair of several groups/programmes; there is no segregation of duties in accountability with the Chief Executive unable to hold themselves to account for delivery.

We also found that some groups scheduled to report to the EC are not decision-making meetings e.g. Civil Contingency Assurance Group and Capital Investment Group; such direct reporting to the EC circumvents delegated executive director accountability, who could routinely provide the assurance.

Key Findings		Risk & Impact	Agreed Management Action
3	**Established Groups reporting to the Executive Committee (EC)** Fourteen Groups and Major Programmes are scheduled to report to the EC although we found new groups having been established but not reflected in the ToR. There is no reporting from these Groups/Programmes into the EC; only the Quality Executive Delivery Group, Risk Scrutiny Group and Executive Policy Oversight Group (via Statutory Compliance Report) reporting regularly. In reviewing papers from the Groups/Programmes, we found the following issues considered at the Groups/Programmes but were not evident through agenda items considered/reported to the EC (and falling within the EC delegated matters): • Agreement to increase catering prices across the Health Board from 5 January 2026 with no evidence of compliance with Standing Financial Instruction 9.3 – Fees and Charges. • Reforecasting a £17m deficit for the Health Board. • Consideration of the recommendations to the Future Generations Commissioner report with no evident reporting to a Health Board Committee found. • The Capital Investment Group is not complying with its Terms of Reference; it has not been chaired by the Executive Director for some time, with its ToR not including the remit set out in the EC ToR. The review of some Groups also noted they were not decision making with some falling under executive director accountability, therefore establishing assurance reporting directly to the EC is unclear when this should fall under	There is a risk that the Executive Committee is not considering key issues or risks due to the lack of reporting from established Groups/Programmes, undermining its ability to ensure the strategic objectives of the Health Board are met. **High Priority**	**Agreed Action:** 1. Review of the Executive Groups with clear terms of reference and frequency of reporting **Expected Evidence of Implementation:** Evidence that there has been a full review of all executive established groups/programmes, associated terms of reference and assurance reporting, i.e. updated terms of reference, reports from groups to Executives. Health Board wide scrutiny and assurance concerning capital and digital matters with reporting to the EC reviewed. **Officer:** Head of Corporate Business **Target Implementation Date:** 31 July 2026

	respective executive assurance reporting. We also noted a gap in assurance to the EC as there is no routine reporting on both digital and capital related matters. **Theme:** Reporting	 Control Operation	
4	**Programmes/Groups Terms of Reference** A review of some Group/Programme terms of reference found that membership frequently overlapped with EC membership—for example, in the Integrated Performance Executive Delivery Group and the Strategic Planning and Service Change Group. This same membership increases the risk of self-reporting, self-assurance and undermines the three-lines model and additional scrutiny. We also noted the Chief Executive is recorded as Chair for several Groups/Programmes and the Chair of EC. Whilst noting this was partly due to executive/corporate director post vacancies, there is now a substantive executive and corporate director team in situ, enabling the delegation to chair the groups/programmes. **Theme:** Governance	There is a risk of self-reporting and self-assurance with a lack of additional scrutiny where membership of groups/programmes is the same as the Executive Committee. **High Priority** Control Operation	**Agreed Action:** 1. Review of the Executive Groups with clear terms of reference and frequency of reporting (linked to 3 above) 2. Review of the leads of each of the EDG and membership to ensure appropriate delegation **Expected Evidence of Implementation:** Evidence that all Group/Programme Terms of Reference and Membership have been reviewed (updated ToRs). Confirmation that chairing of Groups and Programmes has been delegated from the Chief Executive to relevant executives, to support holding officers accountable for delivery. **Officer:** Head of Corporate Business **Target Implementation Date:** 31 July 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
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Audit and Assurance Services

Non DDaT Controlled IT

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-16
Fieldwork	December 2025- February 2026
Executive Sign Off	22nd May 2026
Audit Committee	18 August 2026
Executive Lead	Joint Executives
Audit Team	Dave Harries, Head of Internal Audit Martyn Lewis, IT Audit Manager

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Audit and Assurance Services

Executive Summary

Purpose

To review whether there is an appropriate governance process for the management and use of IT system(s) controlled outside of Digital, Data and Technology (DDaT). Consideration will be given to the accuracy of data held, security, and whether the system is used fully and consistent with the overall strategy and aims of the Health Board.

Where Medical Devices are in use, to ensure appropriate management that patient data is secure, and that devices are updated and are subject to appropriate checks and segregation when connected to the Health Board network.

Overview

We have concluded limited assurance on this area. There are overarching policies for the Health Board, and procedures for management of digital items are held within DDaT. DDaT have instituted a process for evaluating new digital applications to ensure strategic alignment and security, the Cyber team has undertaken an exercise to identify higher risk suppliers and there are controls to block users installing their own software. The network is protected from insecure devices using segmentation with a new module within the firewall providing greater intelligence on connected devices. The matters requiring management attention include:

- The policies in place make clear that all staff who are responsible for managing digital systems have to protect the information / data, however they don't set out any specific requirements, neither is there any guidance information provided by DDaT to other departments.
- There is no sub-committee or forum or Teams Channel which includes representation from across the Health Board that acts as a steering group for Digital and which can ensure strategic alignment for new digital items and ensure compliance with required standards from all across the organisation.
- There is no formal procedure stating the requirement for buyers to confirm and record DDaT approval for software prior to purchase.
- There is a Welsh Government requirement (set out in WHC (2017) 025 Cyber Security & Information Governance) for suppliers of digital systems to be CE+ certified, however not all contracts include this as a mandated requirement within the specification, with it instead being included as a high priority requirement. As specifications can have many requirements, this means that the CE+ aspect may not be fully assessed.
- Due to historic processes, and departments across the Health Board not following the procedure for assessing software there is a wide range of software in use. We also note that as DDaT do not have authority over the Health Boards full digital use there is currently no formal procedure which enables a retrospective assessment of this software and how any software deemed a risk can be managed or replaced.
- There is currently no mechanism to analyse Health Board devices to establish what software is in use such as the Snow asset management software in use elsewhere within NHS Wales; as such DDaT are reliant on other departments providing the information and notifying them of digital items in use, with extant records incomplete or incorrect.
- There is a wide range of software in use, with many suppliers not holding the CE+ certification, having no malware protection and not undertaking timely patching and therefore not complying with minimum security requirements. In many cases these risks are not being recorded within departmental risk registers or on the Asset Register and so the true risk to the Health Board is unquantified.
- Medical devices do not have the access passwords changed from the manufacturer default as part of the set up process, which introduces a risk of unauthorised access to the devices.
- There is no complete record of medical devices and the software installed.

We must report that we did not receive evidence in line with Standing Financial Instruction 3.2.2, with not all staff responding to requests for information about the digital systems used. We also note that DDaT experience the same issue when encouraging uptake of the asset register and risk assessment processes.

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

Scope & Assurance Summary

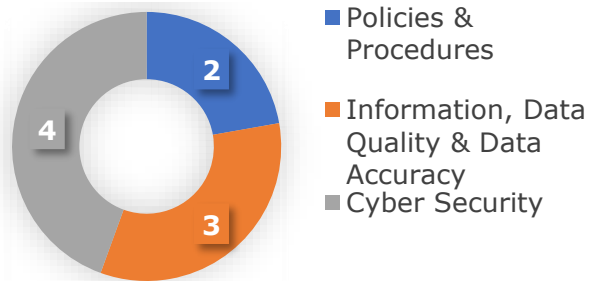
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	IT systems and digital tools procured or managed outside the central IT function (DDaT) are required to comply with relevant digital policies, procedures and guidance and are included within the overall digital governance and oversight arrangements to ensure accuracy of data, security and fully used consistent with overall strategy.	1, 2	**Limited**
2	Procurement and contract management processes prevent unauthorised or duplicate IT systems from being acquired and supported outside of digital services oversight	3, 4	**Limited**
3	Controls are in place to prevent users from downloading and installing software without explicit approval.	5	**Reasonable**
4	Processes are in place to identify shadow IT and ensure risks are managed appropriately (cyber-security, compliance).	6, 7	**Limited**
5	Networked medical devices are appropriately managed ensuring IT infrastructure and security is maintained.	-	**Substantial**
6	Access to medical devices and networked management is appropriately secure	8	**Reasonable**
7	Medical devices are equipped with the latest software versions, where applicable.	9	**Limited**

Management Actions

6 High Priority

3 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: IT systems and digital tools procured or managed outside the central IT function (DDaT) are required to comply with relevant digital policies, procedures and guidance and are included within the overall digital governance and oversight arrangements to ensure accuracy of data, security and fully used consistent with overall strategy	**Limited**

Overview / Summary of Observations

Within DDaT there are a number of procedures and policies in place for the management of digital items and there is also a requirement that all new software is to be assessed by DDaT.

Whilst policies apply across the whole organisation the key relevant ones are the Information Governance Policy and the Security Policy. These make clear that all staff who are responsible for managing digital systems have to protect the information / data, however they don't set out any specific requirements, neither is there any guidance information provided by DDaT to other departments.

There are two committees with a remit that covers digital within the Health Board. The Performance, Finance and Information Governance Committee covers the Information Governance (IG) aspects and the Planning, Population Health and Partnerships covers the development and delivery of plans.

Our review of committee business confirmed that they met the aims of their Terms of Reference and attendance from the membership was good. However there is no executive led forum which includes representation from across the Health Board that acts as a steering group for Digital and which can ensure strategic alignment for new digital items and monitor compliance with required standards from all across the organisation. As such there is limited ability for DDaT to act as the professional leaders for digital across the Health Board and provide guidance to ensure that all digital systems are appropriately controlled.

Our discussions with staff managing digital systems noted that although there is no guidance, staff were generally aware of requirements, with access to systems controlled, although the extent of monitoring of this varies. However due in part to the lack of knowledge of requirements we noted that there were weaknesses in the management and control of digital applications outside of DDaT.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Provision of Guidance** The policies in place make clear that all staff who are responsible for managing digital systems have to protect the information / data, however they do not set out any specific requirements, neither is there any guidance information provided by DDaT to other departments. As such due in part to the lack of knowledge of requirements we noted that there were weaknesses in the management and control of digital applications outside of DDaT.	There is a risk that digital systems will not be managed to the required standard outside of DDaT	**Agreed Action:** *Execs - to clearly state that DDaT are the professional leaders for all digital items, and to communicate to all staff that all departments must follow DDaT guidance* **DDaT** Review of All Digital Guidance, Policies and Procedures A full review will be undertaken of all existing guidance, policies and procedures relating to managing digital systems across the Health Board. Creation of a Central Intranet Location

			A single, central location will be established on the intranet to hold all digital policies, procedures and supporting guidance, making them easy for system owners to locate. **Expected Evidence of Implementation:** DDaT – updated guidance issued.
		High Priority	
	Theme: Policies & Procedures	Control Design	**Officer:** Head of Information Governance /Cyber Security and Resilience Manager/Head Of ICT Digital Services/ Assistant Director Patient Records **Target Implementation Date:** 31/12/26
2	**Oversight Mechanisms** There is no executive led forum or Teams Channel which includes representation from across the Health Board, acting as a steering group for Digital which can ensure strategic alignment for new digital items and ensure compliance with required standards from all across the organisation. As such there is limited ability for DDaT to act as the professional guide for digital across the Health Board and provided guidance to ensure that all digital systems are appropriately controlled.	The ability of the Health Board to monitor and ensure compliance for digital items is reduced.	**Agreed Action:** 1. DDaT -Establish a Teams channel for digital management for relevant staff across the Health Board to participate in and which acts as a channel for digital to provide leadership and professional guidance. 2. All Directors to ensure that all IAOs and system managers join the Teams Channel, and comply with DDaT requirements and guidance **DDaT** Ensure that System Owners are included in the membership of existing Digital Champions, IG Champions and Cyber Champions Viva Engage groups and continue to disseminate professional guidance Organisation-Wide Communication to System Owners Communications will be issued to all system owners setting out the requirement to comply with digital policies, procedures and guidance. Targeted Communications to Asset Owners Further targeted communications will be sent to digital asset owners to ensure they understand the information relevant to their responsibilities. **Expected Evidence of Implementation:** Team Channel established and IAO members of the Channel

			Director to ensure all IAO understand and comply with the guidance Wider membership of core groups Communications to leads within the wider organisation
		Medium Priority	**Officer:** Director of Digital and Members of the Executive Team **Target Implementation Date:** 30/9/26
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 2: Procurement and contract management processes prevent unauthorised or duplicate IT systems from being acquired and supported outside of digital services oversight	**Limited**

Overview / Summary of Observations

There are controls in place to restrict the purchase of unauthorised or inappropriate digital items, with an approved standard list for hardware items and good working relationships between DDaT and Procurement, with regular discussions occurring.

There is a stated requirement within the Health Board for DDaT to be consulted prior to purchasing new software, and a request form to that end is included on the Health Board intranet. Within Procurement the controls for purchasing software depend on the value of the purchase. Where orders are above £5k there is a requirement to obtain formal quotes and as part of this Procurement Services will not progress without DDaT approval. For orders under the £5k the buyers should ask the requestor if DDaT have approved the software, however this process is not formally set out in a procedure, and there is no record of the confirmation received. As such the process relies both on buyers remembering to ask, and the requestors awareness of requirements. We note that from our discussion with Procurement, that end users often are not aware of the need to seek DDaT approval, and in some cases requests are made for orders to be raised to pay an invoice for software that has already been sourced by Health Board staff without following the set process.

As part of our review we tested a small number of purchases of digital items and note that for half of the orders DDaT (either IG or Cyber) were aware and had assessed and approved the software. However the remainder either had not been assessed or had been assessed and been declined by either IG or Cyber. We note that the items without full notification and approval were all under the £5k threshold.

There is a Welsh Government requirement (set out in WHC (2017) 025 Cyber Security & Information Governance) for suppliers of digital systems to be CE+ certified, however not all contracts include this as a mandated requirement within the specification, with it instead being included as a high priority requirement. As specifications can have a large number of requirements, this means that the CE+ aspect may not be fully assessed and suppliers provided with contracts against WG requirements.

From our discussions with managers of digital systems outside of DDaT we also noted that there is limited ongoing contract management for these digital systems and no ongoing monitoring to ensure updates are received appropriately and in accordance with contracts.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Procurement Process** There is no formal procedure stating the requirement for buyers to confirm and record DDaT approval for software prior to purchase.	Unapproved software may be purchased	**Agreed Action:** To issue a communication to all Budget Holders confirming that all that all departments must comply with requirement to contact DDaT for approval before purchasing digital items (Director of Corporate Governance) To develop a formal procedure for buyers to ensure that all digital items receive DDaT approval prior to requisition. In the event of this not being provided, notification of non compliance to be provided to DDaT and the relevant Director for the department. (Director of Digital)

			Expected Evidence of Implementation: Communication to all budget holders Standing Operating Procedure in place Non compliance notifications
		High Priority	**Officer:** Director of Digital / Director of Corporate Governance **Target Implementation Date:** 30/9/26
	Theme: Policies & Procedures	Control Design	
4	**Cyber Essentials+ Requirement** There is a Welsh Government requirement (set out in WHC (2017) 025 Cyber Security & Information Governance) for suppliers of digital systems to be CE+ certified, however not all contracts include this as a mandated requirement within the specification, with it instead being included as a high priority requirement. As specifications can have a large number of requirements, this means that the CE+ aspect may not be fully assessed.	Suppliers may be used which do not meet WG requirements	**Agreed Action:** To ensure all procurement digital contracts to include a requirement CE+. If this is not achievable then SIRO approval to be obtained prior to the tender process.
			Expected Evidence of Implementation: Digital Contracts include CE+ requirement
		High Priority	**Officer:** Director of Finance **Target Implementation Date:** 30/9/26
	Theme: Cyber Security	Control Operation	

Objective 3: Controls are in place to prevent users from downloading and installing software without explicit approval.	**Reasonable**

Overview / Summary of Observations

Guidance is included on the Health Board intranet, including a form for staff to complete in order to request support, which states that DDaT should be informed before purchasing or updating digital systems and which aims to ensure software is secure and compatible with the Health Board environment by requiring DDaT approval for new items.

Controls are in place to prevent users sourcing and installing their own software, with the ability to install being restricted to the administrator role. Software installation requests via the helpdesk are restricted to approved software with new software requiring a new service request, after which the software is vetted by DDaT and if approved added as an available service.

Assessment of digital items should include a Data Protection Impact Assessment (DPIA) to ensure compliance with data protection legislation and to identify the risk level, this is then followed by an assessment within DDaT (Cyber) to ensure security of the system.

There is a record of digital items which have been assessed and the outcome, although we note that some applications are in use despite showing a refusal by the Cyber team. These relate to subsequent approvals by the Senior Information Risk Officer (SIRO) where information has not been passed back to the Cyber team and we note a recent change in the process to remove this information gap.

There are occasions where the process above is not adhered to, and DDaT are presented with already purchased licences for software which is then required to be installed, or discover already installed software. Our testing of digital systems across the Health Board noted that in the main DDaT are aware of the software in use, in part due to the ability to collect information from the network. However in many cases DDaT are unaware of the purpose of the software, who manages and where it is used. We further note that most of the software was not included within the approval record, in part as some were older items, however some newer items were not included on the list and so departments across the Health Board are not following the procedure as set out. We also note that as DDaT do not have authority over the Health Board's full digital use; there is currently no formal procedure which enables a retrospective assessment of this software and how any software deemed a risk can be managed or replaced.

	Key Findings	Risk & Impact	Agreed Management Action
5	**Software Assessment** Due to historic processes, and departments across the Health Board not following the procedure as set out there is a wide range of software in use. We also note that as DDaT do not have authority over the Health Boards full digital use there is currently no formal procedure which enables a retrospective assessment of this software and how any software deemed a risk can be managed or replaced.	Software is in use which does not comply with requirements.	**Agreed Action:** 1. DDaT - Linked to the request for information below, once there is a better understanding of the systems in place and associated risks, consideration will be given to a developing a process for improving the position, either by natural wastage or by better enforcement with suppliers. 2. Executives – clearly state that department managing digital systems are responsible for ensuring they comply with Health Board requirements. **DDaT** Risk Assessments of existing systems to be carried out with identified risks flagged with System Owners for recording on

			local risk registers. The Cyber Security Team will write to the suppliers highlighting gaps and the commercial benefit to them to improving their posture in compliance with WHC2017.25. Where non-compliant systems are procured, these will be logged in the Information Security Management System (ISMS) non-conformity log, and cross checked with the Asset Register and reported to Execs via inclusion in quarterly IGG reports.
			Expected Evidence of Implementation: Clear process in place to support Record of non conformant systems Inclusion in IGC reporting
		Medium Priority	
	Theme: Cyber Security	Control Operation	**Officer:** Director of Digital and Chief Operating Officer / Head of Information Governance /Cyber Security and Resilience Manager **Target Implementation Date:** 30/9/26 and 31/3/27

Objective 4: Processes are in place to identify shadow IT and ensure risks are managed appropriately (cyber-security, compliance).	**Limited**

Overview / Summary of Observations

There is currently no mechanism to analyse Health Board devices to establish what software is in use such as the Snow asset management software in use elsewhere within NHS Wales, as such DDaT are reliant on other departments providing the information and notifying them of digital items in use.

There is an asset register in place with DDaT, containing both Information assets and IT Systems which contain a large number of digital systems, of which DDaT only manage a small number, although hosting is generally provided. However the information is incomplete in some cases, with no asset owner or administrator named, or incorrect names included. We note that DDaT have previously tried to obtain this information, but responses have been limited.

We note that there has been work ongoing within the Cyber team to identify and risk assess suppliers of digital systems. Suppliers were identified from a variety of sources, including the historical list of software approvals, the asset register and a report from NWSSP Procurement Services; Suppliers were then contacted and asked to complete a form to collect key information such as whether malware protection is in place, the CE+ certification status, attitude to incident reporting etc.

From our work cross referencing the separate records of digital items we note that they are not consistent, with not all items included in the Information Asset Register (IAR) or the cyber scorecard and incomplete information regarding ownership; we also note that the IAR contains items that are no longer in use. As such there is no complete, accurate record of what digital systems and suppliers are in use across the whole organisation.

From the information collected by the Cyber team, a risk based scorecard has been developed and we note that there are a number of suppliers flagged as high risk, with some responses noting no malware protection, no timely patching and no CE certification. Control over these lies outside of DDaT, although there is some mitigation with DDaT removing remote access for these suppliers, and we note the intent is to contact the service to establish how suppliers and digital systems are managed.

Currently there is a wide range of software in use, with many suppliers not holding the CE+ certification and not complying with minimum security requirements and therefore operating at risk. Our discussions with managers of these systems noted that in many cases this risk is not being recorded within their risk register and so the true risk to the Health Board is unquantified.

We also note that there is no process to enable DDaT to enforce minimum requirements across the Health Board, and there is no process, or resource within DDaT to enable the resolution of these issues, monitor compliance and coordinate digital systems across the whole organisation.

	Key Findings	Risk & Impact	Agreed Management Action
6	**Identification of Digital Systems** There is currently no mechanism to analyse Health Board devices to establish what software is in use such as the SNOW software in use elsewhere within NHS Wales, as such DDaT are	Digital systems may contain security vulnerabilities.	**Agreed Action:** 1. Formulate a mail to senior managers requiring staff to complete the form / IAR with information on all their digital applications.

	reliant on other departments providing the information and notifying them of digital items in use. We further note that the asset register in place contains incomplete information in some cases, with no asset owner or administrator named, or incorrect names included. We note that DDaT have previously tried to obtain this information but responses have been limited. From our work cross referencing the separate records of digital items we note that they are not consistent, with not all items included in the IAR or the cyber scorecard and incomplete information regarding ownership. As such there is no complete, accurate record of what digital systems and suppliers are in use across the whole organisation.		2. Send the mail (drafted by DDaT) asking for details on digital application with a clear statement that managers must comply. **DDaT** ICT have the capability to review locally installed software through SSCM and Defender. The gap here relates to our ability to identify where staff are using CLOUD based software without permission. This is a difficult balance i.e. draconian web filtering policies which prevent staff from working vs. controlling access to unsanctioned Apps. action:-Investigate technology solutions which would allow the catalogue and monitoring of Cloud based software by staff. **Expected Evidence of Implementation:** Communication to Senior Managers IAR updated to reflect the compliance **Director of Digital and Members of the Executive Team** Record of all systems, including cloud based
		High Priority	**Officer:** Director of Digital and Members of the Executive Team **Target Implementation Date:** 30/9/26
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
7	**Software Risk** There is a wide range of software in use, with many suppliers not holding the CE+ certification, having no malware protection and not undertaking timely patching and are therefore not complying with minimum security requirements. In many cases these risks are not being recorded within departmental risk registers and so the true risk to the Health Board is unquantified. We also note that there is no process to enable DDaT to enforce minimum requirements across the Health Board, and there is no process or resource within DDaT to enable the resolution of these issues and coordinate digital systems across the whole organisation.	There is a risk ok loss of data or services and of inappropriate access to information.	**Agreed Action:** 1. Each Director to undertake a review of systems and identify areas of non-compliance with CE+ and this will be reported to the appropriate governance group. **DDaT** Risk assessments of existing systems will be undertaken, with any identified risks highlighted to System Owners for inclusion on their local risk registers. The Cyber Security Team will also contact suppliers to outline any identified gaps and emphasise the commercial benefits of improving their security posture in line with WHC 2017.25. Audit spot checks will be introduced to confirm that System Owners are accurately recording risks on their local registers and that risk scoring is applied consistently.

			Where non-compliant systems are procured, these will be recorded in the Information Security Management System (ISMS) non-conformity log. Entries will be cross-checked with the asset register and reported to Executives through quarterly IGG reports.
			Expected Evidence of Implementation: Communication to senior managers Inclusion of risks within local registers Inclusion in IGC reporting
		High Priority	**Officer:** Director of Digital / Head of Information Governance /Cyber Security and Resilience Manager
	Theme: Cyber Security	Control Operation	**Target Implementation Date:** 30/9/26

Objective 5: Networked medical devices are appropriately managed ensuring IT infrastructure and security is maintained.	**Substantial**

Overview / Summary of Observations

Access to the network is controlled by DDaT and there is a formal onboarding process in place to allow medical devices onto the network which clearly sets out the process for various operating systems. To enable network access the department has to complete a form which is then subject to a formal assessment. The form contains some automatic responses to prevent devices being added which don't meet security standards, such as blocking devices with old or out of support software.

The Health Board has purchased the Internet of Things (IoT) module for the firewall which enables better identification and monitoring of devices that are connected to the network, and which provides a risk rating for each device based on the Common Vulnerabilities & Exposures (CVE) score. We note that there are several devices classified as high risk and with out of date software/firmware, however DDaT have limited ability to enforce better security over other departments and limited resource for ongoing monitoring and enforcement.

Our review confirmed that devices are segmented within the network, with devices flagged as higher risk separated into their own, category specific Virtual Local Area Network (VLAN), mainly within the Demilitarised Zone (DMZ) to provide greater security. Devices representing significant risks are further restricted using Access Control Lists (ACLs) to restrict their access to very specific connections. We note that both of these represent good practice in network management.

There are technical controls that protect the network, with automatic shutdown of wall ports if unused for 6 weeks, although we note that a device can be unplugged and a new device plugged in. Network segmentation is in use which separates traffic into separate functional areas with defined VLANS for departments using networked devices e.g. Radiology. The network architecture has grown organically to a large extent, however we note a move towards standardisation across all sites and a record of VLANS is in place along with specified standards for the team to follow and a technical design authority that brings key staff from within the infrastructure related teams together to better enable formalised, secure design of services.

We note an intent within DDaT to fully utilise the capability within Cisco Identity Services Engine (ISE) for Media Access Control (MAC) filtering which will enable fully granular network device control and fully secure the network from new devices, however this work is resource intensive.

There is segmentation for departmental applications using application centric infrastructure within the hosting environment enabling the restriction of application traffic.

Objective 6: Access to medical devices and networked management is appropriately secure	**Reasonable**

Overview / Summary of Observations

Medical devices are managed in a number of departments. The EBME Department manages the majority of devices, although we note that Radiology manage their devices and Cardiology manage pacemakers.

There is a full record of medical devices held and controlled by EBME to enable the management of the devices. A large number of medical devices are on the Health Board network, although in the main, apart from infusion pumps, medical devices are not wireless enabled and so not accessible in that way. Access to devices is protected by passwords, however medical devices do not have the access passwords changed from the manufacturer default as part of the setup process, which does introduce risk of unauthorised access to the devices.

Access to pacemakers is via manufacturer specific computer (programmer), held within the department, which communicates via an encrypted Bluetooth connection. Pacemakers do not have passwords due to the clinical need for rapid access, although research has demonstrated the potential for inappropriate access, the risk is low.

	Key Findings	Risk & Impact	Agreed Management Action
8	**Medical Device Passwords** Medical devices do not have the access passwords changed from the manufacturer default as part of the set up process, that does introduce risk of unauthorised access to the devices.	Unauthorised access to devices	**Agreed Action:** The EBME Department to ensure as devices come through the departments, passwords to be changed from the default to BCU defined passwords. **DDaT** Review the IG14 Security Policy to ensure password policy requirements for MIoT is covered.
			Expected Evidence of Implementation: Evidence of changes to passwords and clear process in place
		Medium Priority	**Officer:** Executive Director of Allied Health Professionals and Health Science / Cyber Security and Resilience Manager
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** 31/12/26

Objective 7: Medical devices are equipped with the latest software versions, where applicable.	**Limited**

Overview / Summary of Observations

The IoT module within the firewall enables the identification of devices that connect to the network with old software and firmware and provides an indication of the risk. DDaT periodically request that departments update, however they cannot enforce, and there is no formal process that sets out how these devices are to be flagged, escalated and managed. We note that in many cases the older software is due to the inability to update and maintain device stability, and although these are subject to access restrictions, some do contain security vulnerabilities.

The report shows a large number of connected devices including security, building management, medical devices, cameras etc and as such shows a large underlying source of risk. Medical devices do not all have the operating system (OS) identified, however for those that do there are several connected devices with old, out of support OS:

- Windows 10 - support ended October 2025, with extended support ending in October 2028 - (358);
- Windows 7 – support ended January 2023 – (26);
- Window XP – (1);
- Windows Server 2008 – (1); and
- Plus Linux – (128).

The firewall report highlights the risks from these, with the higher risk devices being segmented within separate VLANS:

- One hundred and sixty-eight (168) flagged as critical;
- Twenty-eight (28) flagged as high;
- Four thousand nine hundred and ninety one (4,991) medium and four hundred and sixty eight (468) low.

Medical device software is not routinely updated, with updates provided solely by the manufacturer following extensive compliance and validation testing to ensure the device operates within in specified performance parameters. The majority of medical devices are managed by EBME and the updates are made on the basis of field safety notices that provide warnings and to address identified safety or performance issues—. We note that the majority of devices are not on the network which reduces the risk to the wider organisation, although many are.

In general, the process for updating devices is a manual one to protect patient safety and prevent devices rebooting at inappropriate times. Updates are tested on test devices by key staff prior to rolling out on a wider basis.

EBME keep an inventory of all devices which contains information about the software version, however this is incomplete and has been reliant on manual entry, although we note a greater focus on updating as devices are updated. As such there is no complete record of medical devices and the software installed.

Pacemakers are managed within the Cardiology Department with any updates provided when the device connects to the central unit within a clinic. The provision of updates onto the central units is the responsibility of the providing company.

The Health Board have contracts for purchase with some companies however patients have moved into the area with alternate devices, and some patients have had devices implanted elsewhere. In the event of a Field Safety Notice the Centricity Cardio Workflow system in use is searchable by serial number and will then track the device.

However, there is no complete, easily accessible records of the pacemakers in use across the Health Board population and the software version in use. As such the Health Board has no way of gaining assurance that all devices are updated appropriately. We note that we have not raised a matter to update all software as it may impact delivery of patient services.

Key Findings		Risk & Impact	Agreed Management Action
9	**Device Records** There is no complete record of medical devices and the software installed which would enable the full risk picture to the organisation to be established. Similarly there is no complete, easily accessible records of the pacemakers in use across the Health Board population and the software version in use.	The Health Board has no way of gaining assurance that devices are updated appropriately and that security is maintained.	**Agreed Action:** 1. To deliver the implementation of Scan for Safety as agreed at the Executive Committee ensuring that capture of operating system and records will be place.
			Expected Evidence of Implementation: System Implementation
		High Priority	**Officer:** Executive Director of Allied Health Professionals and Health Science (Medical Director of the SRO for the Project)
	Theme: Cyber Security	Control Operation	**Target Implementation Date:** 31/12/26

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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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.

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.

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Standards of Business Conduct

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-04
Fieldwork	March – April 2026
Executive Sign Off	19 May 2026
Audit Committee	June 2026
Executive Lead	Pam Wenger, Director of Corporate Governance
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the compliance with the Standards of Business Conduct (SOBC) policy.

Overview

There has been an improvement in the operation of controls in place since the last audit in terms of prompting staff to submit declarations of interest (DOI), and a more efficient system for capturing and monitoring the declarations of interest of Board members. However, there continues to be limitations with the system and the accuracy of the number of declarations submitted.

We have concluded limited assurance on this area as, overall, we are unable to confirm that the system and process for managing declarations, gifts and hospitality is operating effectively. The matters requiring management attention include:

- Whilst there is a policy in place and the Governance intranet site details the requirements for DOI's, gifts and hospitality, the low compliance rate amongst staff at band 8c and above suggest there is a lack of awareness of the policy, despite reminders being sent from the system. It is noted actions are underway to address this, including adding a section for declarations of Personal and Development Review (PADR) forms; however this is not yet in place.
- There is limited evidence of regular reporting to the Executive Committee on DOIs etc., which is not in line with the monitoring requirements set out in the Standards of Business Conduct Policy - the last report was in April 2025. The Audit Committee have received information on Declarations, Gifts and Hospitality; however this could be refined to ensure the Committee is able to discharge its responsibilities in line with its terms of reference.
- Senior managers at band 8c and above are required to submit a declaration (including nil declarations), however only 54% of these have done so. Also a review of consultants who are noted in the directory of a private hospital demonstrate the majority of these do not have a declaration submitted to note private practice undertaken.
- It is noted there are restrictions with the system that limit the ability of the Corporate Governance Team to review and address non-compliance.
- The declarations of gifts, hospitality and sponsorship events are typically not recorded in a timely manner, often at least a few weeks after the offer /event.

We note that the Corporate Governance Improvement Plan includes an action to address issues with SOBC compliance, which is in progress and due to be completed by March 2027.

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

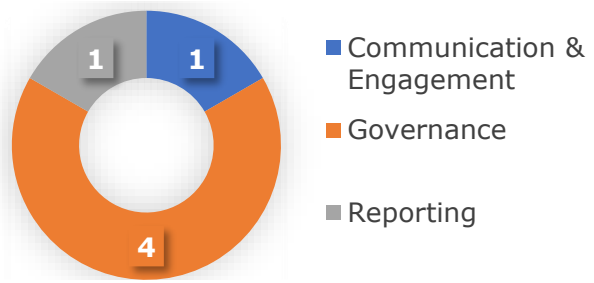
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Health Board has a Standards of Business Conduct policy in place to support compliance with Standing Orders, with requirements and responsibilities clearly outlined. There is suitable training and awareness to ensure that new and existing staff understand their responsibilities, expectations and requirements of the policy.	1	**Reasonable**
2	There are effective systems and processes in place to capture Declarations of Interest, Gifts and Hospitality, with appropriate reporting to the Audit Committee.	2	**Reasonable**
3	Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly and escalated where appropriate.	3,4,5	**Limited**
4	Submissions of gifts and hospitality are reviewed to ensure they are in line with policy requirements, and suitable action taken where issues are identified.	6	**Limited**

Management Actions

4	2
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Declarations - At a Glance

2025/26 declarations of interests submitted for decision makers (Band 8C and above)

	Staff count	**Declarations Made**	**Staff that have not made a declaration**
2025/26	2407	1307 (54%)	1100 (46%)

Findings & Agreed Action Plan

Objective 1: The Health Board has a Standards of Business Conduct policy in place to support compliance with Standing Orders, with requirements and responsibilities clearly outlined. There is suitable training and awareness to ensure that new and existing staff understand their responsibilities, expectations and requirements of the policy.	**Reasonable**

Overview / Summary of Observations

Policy and guidance

The Health Board has a Standards of Business Conduct (SOBC) Policy in place that outlines the expectations and requirements of standards of conduct of all staff. The Policy is available via the Corporate Governance intranet page on BetsiNet, and was reviewed and approved by the Audit Committee in January 2025 and activated in April 2025. The Policy includes advice and guidance for staff on the responsibilities, requirements and processes for managing declarations. The Corporate Governance BetsiNet pages summarised the main points of the Policy, directing staff to the Policy and WP6 Code of Conduct.

The Policy has been updated to reflect issues raised in our previous review of Standards of Business Conduct in 2024.

Training and awareness

The requirements and responsibilities regarding declarations of interest, gifts and hospitality are included in the Board Induction Handbook for Independent and Associate Members.

There is no specific reference to Standards of Business Conduct, declarations, gifts or hospitality included in the staff induction handbook, however the handbook encourages new members of staff to familiarise themselves with Health Board policies.

Despite the absence of formal training provision, the Health Board has processes in place to notify staff of their responsibilities and has communicated this via weekly bulletins, the Corporate Governance BetsiNet pages, and standard emails from the 'declare' system.

The Performance Appraisal and Development Review (PADR) document has recently been revised, and we were provided with e-mail confirmation that the form now includes the question 'Have you registered any declaration of interest?'. It should be noted this form is not yet in operation, and we do not have a date of implementation.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Awareness of Policy requirements** The Policy is available to staff via the Health Board intranet; however, testing suggests that further work is required to embed staff understanding and consistent compliance with the Policy requirements.	There is a risk that where staff do not understand or consistently comply with the Policy, the Health Board may be exposed to breaches of standards of	**Agreed Action:** The Corporate Governance Team will implement a targeted programme of communication and awareness to reinforce staff understanding of the Standards of Business Conduct Policy and individual responsibilities for declarations of interest, gifts and hospitality. This will include refreshed guidance on BetsiNet, periodic communications via corporate bulletins, and specific messaging for senior decision-makers. The revised Performance Appraisal and Development Review (PADR) process will be used

		business conduct, leading to conflicts of interest, regulatory non-compliance, and potential reputational and financial harm.	to prompt compliance with declaration requirements once implemented. **Expected Evidence of Implementation:** Increase in declarations made through wider awareness sessions. • Evidence of updated SOBC guidance and communications issued • Increased compliance rates for declarations of interest over the reporting period • Confirmation of PADR implementation including declaration prompt
		Medium Priority	**Officer:** Director of Corporate Governance **Target Implementation Date:** 31 March 2027
	Theme: Communication & Engagement	Control Design	

Objective 2: There are effective systems and processes in place to capture Declarations of Interest, Gifts and Hospitality, with appropriate reporting to the Audit Committee. **Reasonable**

Overview / Summary of Observations

System

Declarations are submitted via the 'Declare' system, which is available to all staff via BetsiNet. The system issues reminders to staff to complete declarations. We were provided with a list of scheduled notifications and notification logs to confirm that communication had been issued to staff.

We were provided with a number of reports from the Office of the Director of Corporate Governance, and we also reviewed the information on the Declare system that is available on the intranet site.

Review of declarations

The system requires line managers to approve declarations made. A review of all declarations submitted during 2025/26, which includes all categories such as gifts, nil declarations, outside employment etc., shows that of the 2400 declarations submitted:

- 2051 (85%) had been reviewed and approved
- 29 (1%) had been reviewed and not approved
- 205 (8%) were pending approval
- 115 (6%) were not applicable for approval (all nil declarations)

A System overview report detailing new declarations is received and reviewed weekly by the Head of Corporate Affairs. Whilst there is some evidence of the Corporate Governance Team responding to queries, the report includes items overdue for approval, such as outside employment and loyalty interests, which at the time of this report, had not been approved or escalated (see finding 3 for details).

Reporting

The Policy sets out the requirements, including frequency, for the monitoring and reporting of declarations, gifts and hospitality.

Executive Committee Reporting

The Policy states that declarations, gifts and hospitality will be reported to Executives on a quarterly basis. We are advised reporting to the Executive Committee has not been as frequent as required; a review of Executive Committee Papers show information on declarations was last reported in April 2025.

Audit Committee Reporting

The Policy states there will be reporting to the Audit Committee on a six monthly basis, including the full register. Audit Committee Terms of Reference include 'The Committee will receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the Health Board and report to the Board the adequacy of these arrangements . A review of Audit Committee papers from April 2025 onwards show that information on declarations is regularly reported, usually within the Corporate Governance report in May, October and December 2025, with a further update on SOBC in April 2026. This includes a link to the full register and provides high level details of compliance. However, there is a lack of detail on compliance within areas across the organisation – we recognise this is due to issues with reporting from the current system.

Key Findings		Risk & Impact	Agreed Management Action
2	**Reporting** The Standards of Business Conduct Policy states Executives will receive reporting on a quarterly basis, and the Audit Committee on a six monthly basis. A review of evidence confirms the Executive Committee last received information on declarations, gifts and hospitality in April 2025. The Audit Committee Terms of Reference do not align with the Standards of Business Conduct Policy, stating reporting will be on an annual basis, whereas the Policy states six monthly. However there is regular reporting to the Audit Committee, which is high level and does not include compliance across areas of the Health Board or exceptions / non-compliance with the policy.	There is a risk that inconsistent reporting to the Executive Committee and Audit Committee reduces visibility of compliance with the standards of business conduct policy, potentially allowing issues to go unidentified or unaddressed. It also limits the ability to provide effective oversight and challenge.	**Agreed Action:** Reporting arrangements for declarations of interest, gifts and hospitality will be formalised and strengthened to ensure compliance with the Standards of Business Conduct Policy. A regular reporting schedule will be re-established to the Executive Committee, with six-monthly reporting to the Audit Committee aligned to policy requirements. The Standards of Business Conduct Policy and relevant Terms of Reference will be reviewed to ensure consistency, clarity of frequency, and clear accountability for oversight. **Expected Evidence of Implementation:** Regular reporting to the Executive Committee on the Standards of Business Conduct Compliance. Policy reviewed to ensure consistency with established Terms of Reference. • Evidence of regular reports submitted to Executive Committee • Six-monthly reports presented to Audit Committee

			• Updated policy and/or Terms of Reference approved through appropriate governance routes
		Medium Priority	**Officer:** Director of Corporate Governance
	Theme: Reporting	Control Operation	**Target Implementation Date:** 31 October 2026

Objective 3: Compliance with the requirements for submitting Declarations of Interest for all required staff, including Board members, is reviewed regularly and escalated where appropriate.	**Limited**

Overview / Summary of Observations

The requirements for the submission of declarations of interest is set out in point 8.6 of the Policy *'Mandatory annual declarations of interests are required from Board members, all senior employees (band 8c or equivalent and above), all Consultants and also other employees of any pay band deemed to be undertaking roles where there is potential for a conflict of interest (as determined by a Director). Annual declarations must be submitted even if a nil return (nothing to declare).'*

Board member declarations are managed separately by the Corporate Governance Team, whilst staff at band 8c and above are required to submit their declarations via the Declare system.

Declarations – Board members

The public register of Board Member declarations is published on the Health Board internet site. We are advised this is a live version although there is no date noting when it was last updated. We reviewed a sample of ten declarations to confirm the register was up to date, and that submissions were current at the time of testing. All submissions were provided; however we note a number were not signed, but stated that hard copies were signed. We reviewed Companies House and Charity Commission records for a sample of ten Board Members to determine whether there were any that had not declared current appointments or interests. No issues were identified.

We are advised there has been no requirement to escalate any non-compliance with Board Member declarations in 2025/26 as all were completed when due.

Declarations – Band 8c and above

We reviewed the Declare system to establish the current compliance with staff 8c and above (decision makers). As of 15 April 2026, there were 2,326 decision makers noted, of which, 1,296 (56%) had submitted a declaration and 1,030 (44%) had not submitted a declaration.

We reviewed a sample of 20 senior managers – 16 (80%) had submitted a declaration.

Declarations – private practice

We reviewed a sample of 61 consultants who are included in the 2026 Consultant directory for a local private hospital (March 2026), to confirm whether all had declared their private practice interest. A review of the information in the Declare system noted that of the 61 Health Board consultants included in the directory, 29 (48%) did not have a declaration for private practice on the declare system.

Review, reporting and escalation

As noted in objective 2 above, whilst some evidence of the Corporate Governance Team addressing queries with declarations were provided, and reports with submitted declarations are reviewed, there does not appear to be any identification of breaches and escalation to relevant areas. We note that this is difficult due to restrictions with the system and is an issue management recognise further work is required to ensure robust oversight.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Review and escalation of non-compliance** Whilst some evidence of the Corporate Governance Team addressing queries with declarations were provided, and reports with submitted declarations are reviewed, there does not appear to be any identification of breaches and escalation to relevant areas. We note that this is difficult due to restrictions with the system and it is noted that it is planned that the Corporate Governance Team will be monitoring for any breaches of the policy. A review of the system report provided to the Corporate Governance Team in March 2026 details declarations that have not been approved. At the time of reporting a number of these declarations, including loyalty interests and outside employment dating back to April and May 2025, had not yet been approved or escalated.	There is a risk that breaches of the Standards of Business Conduct Policy are not consistently identified, escalated, or managed. This may result in unmanaged conflicts of interest, weakened governance, and reputational damage to the Health Board.	**Agreed Action:** A formal process will be implemented for the identification, monitoring and escalation of non-compliance with the Standards of Business Conduct Policy. This will include regular review of overdue and unapproved declarations, defined escalation routes to Executive Directors and operational leads, and documented follow-up actions. Limitations of the current system will be mitigated through manual oversight controls until system improvements are delivered. **Expected Evidence of Implementation:** Regular reporting to operational leads with assurance received on steps taken. • Documented escalation process and thresholds • Evidence of regular review and follow-up of overdue or unapproved declarations • Assurance reports demonstrating action taken where non-compliance is identified
		High Priority	**Officer:** Director of Corporate Governance **Target Implementation Date:** 31 December 2026
	Theme: Governance	Control Operation	
4	**Declaration of Interest Compliance – band 8c and above** Current compliance with Declarations of Interest for band 8c and above (decision makers) is at 54%. We are advised it is difficult to obtain accurate figures as the information in the system is reconciled to the Electronic Staff Record system, which can include duplicate staff.	Undeclared or unmanaged conflicts of interest may influence key decision making by senior managers.	**Agreed Action:** Action will be taken to improve declaration of interest compliance rates for staff at Band 8c and above. This will include reconciling Declare system data with ESR to improve accuracy, targeted follow-up with non-compliant individuals, and escalation to Executive Directors where required. Compliance levels will be monitored and reported as part of routine governance reporting **Expected Evidence of Implementation:**

			All officers who should have completed a declaration has done so in the reporting year. • Improved accuracy of decision-maker data sets • Increased compliance rates for mandatory annual declarations • Evidence of escalation where declarations remain outstanding
		High Priority	**Officer:** Director of Corporate Governance **Target Implementation Date:** 31 December 2026
	Theme: Governance	Control Operation	
5	**Declaration of Interest Compliance - private practice** A review of 61 consultants listed in a local private hospital directory as having a base of a Health Board hospital were reviewed. Of these 61, 29 had not declared their private practice interest on the DOI system.	Undeclared private work by consultants may result in unmanaged conflicts of interest that undermine patient trust, compromise clinical decision-making, and expose the Health Board to legal, financial and reputational harm.	**Agreed Action:** The Health Board will strengthen arrangements to ensure consultants undertaking private practice declare these interests in line with policy requirements. This will include targeted communication to the Medical and Dental workforce, alignment with job planning and appraisal processes, and operational management oversight. Non-compliance will be escalated in line with the revised escalation framework.
			Expected Evidence of Implementation: Increase in Medical and Dental workforce declaring of private practice in line with job planning with operational management oversight. • Increased percentage of consultants declaring private practice • Evidence of alignment with job planning and appraisal • Management assurance on follow-up of non-compliance
		High Priority	**Officer:** Executive Medical Director **Target Implementation Date:** 31 December 2026
	Theme: Governance	Control Operation	

Objective 4: Submissions of gifts and hospitality are reviewed to ensure they are in line with policy requirements, and suitable action taken where issues are identified.	**Limited**

Overview / Summary of Observations

We reviewed the gifts, hospitality and sponsored events recorded on the Declare system from 1 April 2025 to 12 March 2026, and reports provided by management. It should be noted there is additional detail provided on the declarations system than via the reports provided by management, such as amounts and further detail. A summary of our testing on each area is provided below.

Gifts

There were 63 gifts declared; 24 (38%) of these were declared after 28 days, with the longest declared after 79 days. We identified two gifts that should have been declined or donated, but were accepted (bottle of alcohol and a £50 voucher).

59 of the submissions were approved, three were pending and one was not approved.

Hospitality

A review of the Declare system noted sixteen hospitality instances declared; four (44%) of these were declared after 28 days, with the longest declared after 59 days. Two of the declarations did not have a value included.

Sponsored events

There were ten sponsored events noted on the Declare system, five (50%) of these were declared after 28 days, with the longest declared after 144 days.

The Standards of Business Conduct Policy states gifts and hospitality will be monitored on a monthly basis. Whilst we were provided with evidence of queries and issues, it is noted that this is not undertaken on a regular basis.

Key Findings		Risk & Impact	Agreed Management Action
6	**Gifts, hospitality and sponsored events** The Standards of Business Conduct Policy sets out clear guidance and monitoring arrangement for the declaration of gifts, hospitality and sponsored events. From our testing, there is a delay staff declaring gifts, hospitality and sponsored events, often until some time after the event. There is also limited evidence to demonstrate these are being reviewed by the Corporate Governance Team on a regular basis.	There is a risk that conflicts of interest arising from gifts, hospitality and sponsored events are not being identified, reviewed or managed effectively, due to delays in declarations and limited evidence of regular review by	**Agreed Action:** Arrangements for the monitoring and review of gifts, hospitality and sponsored event declarations will be strengthened to ensure timely declaration and consistent review. The Corporate Governance Team will undertake regular reviews in line with policy requirements and act where decisions breach policy or timescales are not met. Expectations will be reinforced with staff through refreshed guidance. **Expected Evidence of Implementation:** The Corporate Governance Team reviews all records and takes action if a decision breaches Policy compliance.

		the Corporate Governance Team.	• Evidence of routine review activity by the Corporate Governance Team • Reduced delays in declaration timescales • Records of action taken where declarations breach policy
		High Priority	**Officer:** Director of Corporate Governance **Target Implementation Date:** 31 December 2026
	Theme: Governance	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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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.

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.

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

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Pharmacy Regulatory Compliance

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-40
Fieldwork	March 2026
Executive Sign Off	4 June 2026
Audit Committee	June 2026
Executive Lead	Dr. Clara Day, Executive Medical Director
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Rhys Jones, Principal Auditor

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the effectiveness of established processes and governance arrangements for managing and maintaining compliance with General Pharmaceutical Council (GPhC) Standards for Chief Pharmacists (January 2025).

Overview

Review findings are based on information and evidence provided by the three Integrated Health Community (IHC) Area Directors of Pharmacy and Medicines Management. The comprehensiveness of responses and supporting evidence varied across areas.

To support our work against Objective 1, we sought the views of relevant staff. An audit questionnaire was issued to 465 acute hospital pharmacy staff, generating 122 responses: East (49), West (38) and Central (35). Aggregate data has been used for reporting purposes; however, it should be noted that the issues identified may not apply equally across all areas.

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

- Pharmacy leadership arrangements within the Health Board lack clarity, particularly in relation to the authority and remit of the Chief Pharmacist. The current arrangement creates a structural inconsistency between professional accountability and operational reporting lines and we are unclear how Foundations for the Future will address this significant risk.
- Despite areas documenting clear leadership structures, leadership arrangements were not well understood in practice, with only 43% of staff understanding their Director's role and responsibilities. Although 57% of staff fully understood their own responsibilities, 41% reported only partial clarity, and 36% of respondents did not understand who was accountable for key decisions and actions within their area of work. Free-text feedback highlighted limited leadership visibility and unclear accountability.
- Governance processes are not consistently understood or experienced, with 20% of staff unsure how to escalate concerns, 52% not confident that raising a concern will lead to appropriate action, and 75% not aware of staff protections under the error reporting defences. Free-text feedback highlighted irregular meetings and limited feedback.
- Operational processes showed variability, with 28% of staff reporting difficulty accessing up-to-date Standard Operating Procedures (SOPs), 49% unclear on delegated authority, and staff feedback describing pressures such as workload, staffing constraints and EPMA-related disruption affecting consistency. Forty percent (40%) of staff did not feel confident when required to take on additional or extended responsibilities, and 60% reported that they did not receive appropriate support.
- Thirty percent (30%) of respondents are not confident reporting professional concerns, despite the Health Board's investment in Speaking Up Safely Guardians. This issue may affect patient safety and should be urgently addressed by management. Improvement action monitoring arrangements remain under-developed, with no dedicated tracker in place for regulatory actions and unclear processes for ensuring such actions are consistently captured, monitored, and escalated.
- There is no systematic post-implementation review framework to assess whether completed actions have led to sustained improvements, with current impact monitoring limited to incident trend analysis and future KPIs still under development.
- Assurance reporting to the Health Board Chief Pharmacist is not routinely undertaken, limiting the level of corporate oversight and assurance available.

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

Scope & Assurance Summary

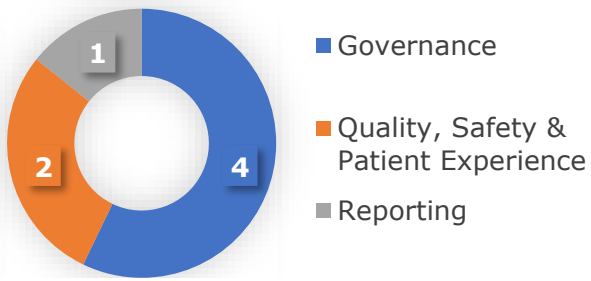
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate leadership, governance and accountability arrangements are in place to support compliance with the GPhC Standards for Chief Pharmacists, including clarity over how Chief Pharmacist responsibilities for hospital services are delegated and discharged, clearly defined roles and responsibilities, approved policies and Standard Operating Procedures, and effective oversight, assurance and escalation mechanisms.	1, 2, 3, 4	**Limited**
2	Effective processes are in place to monitor compliance, identify gaps or risks, and manage improvement actions. Where deficiencies are identified, corrective actions are implemented, tracked and reviewed to support continuous improvement and patient safety.	5, 6, 7	**Limited**

Management Actions

7 High Priority

0 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Appropriate leadership, governance and accountability arrangements are in place to support compliance with the GPhC Standards for Chief Pharmacists, including clarity over how Chief Pharmacist responsibilities for hospital services are delegated and discharged, clearly defined roles and responsibilities, approved policies and Standard Operating Procedures, and effective oversight, assurance and escalation mechanisms.	**Limited**

The Health Board's pharmacy leadership arrangements lack clarity, particularly in relation to the role, remit and authority of the Health Board Chief Pharmacist. The formal job description places responsibility for leading and delivering an integrated medicines management and pharmaceutical service across BCUHB with the Chief Pharmacist; however, the three Area IHC Directors of Pharmacy and Medicines Management are line-managed by their respective IHC Directors rather than by the Chief Pharmacist. This creates a structural inconsistency between professional accountability and operational reporting lines.

The Directors of Pharmacy and Medicines Management provided evidence of documented governance and leadership structures, including defined roles and responsibilities, established escalation pathways, and SOP management systems. To test how these arrangements operate in practice, a questionnaire was issued to 465 acute hospital pharmacy staff, generating 122 responses: East (49), West (38) and Central (35).

We did note that senior pharmacy leadership capacity in the East area has been significantly depleted over the last twelve months due to vacancies, long-term sickness absence, and maternity leave. Whilst temporary arrangements have been implemented to backfill some vacancies, including the acting-up of staff to cover more senior roles, we were unable to confirm that all acting-up or secondment arrangements were supported by documented formal capability or competency assessments. Staffing challenges were reflected in the responses of East staff and have been formally recorded within an East Area Pharmacy Acute Services Staffing SBAR (dated 10 February 2026) and Draft Operational Workforce Plan (dated 27 January 2026); however, no information was provided regarding the status or progress of these plans.

Staff feedback indicates that while leadership and governance frameworks exist, they are not consistently embedded or understood across areas / services. Only 43% of respondents understood their Director's responsibilities, 28% reported difficulty locating up-to-date SOPs, and 20% did not understand escalation routes. Although 57% of staff reported fully understanding their own responsibilities, 41% only partially understood them, highlighting variability in operational clarity despite documented role structures. Thirty percent (30%) of respondents stated that they did not feel safe reporting professional concerns, errors or near misses without fear of blame, and 75% were not aware of staff protections under the error reporting defences. Despite some variation in response patterns across questions, the data showed that the East area had the lowest proportion of 'positive' responses for fourteen of the twenty-three questions.

Free-text responses raised several concerns, including poor leadership visibility, communication gaps and insufficient support during periods of operational pressure, particularly throughout the EPMA rollout. Although delegation frameworks are described in management submissions, only 44% of staff felt delegation decisions were clearly communicated. Forty percent (40%) of staff did not feel confident when required to take on additional or extended responsibilities within their role, and 60% reported that they did not receive appropriate support (i.e. guidance, supervision, training) when assuming additional responsibilities. Workforce pressures, including understaffing and increased workload, were strongly reflected in staff comments.

Overall, evidence demonstrates that leadership, governance, accountability, SOP management and delegation structures are in place but not reliably functioning in practice. Quantitative data point to gaps in understanding and confidence, while qualitative evidence highlights inconsistent implementation, operational strain and notable variation between areas.

Key Findings		Risk & Impact	Agreed Management Action
1	**Chief Pharmacist Role and Remit** Pharmacy leadership arrangements within the Health Board lack clarity, particularly in relation to the authority and remit of the Chief Pharmacist. Although the Chief Pharmacist is the designated professional lead for the integrated medicines management and pharmaceutical service across the Health Board, the three Area Directors of Pharmacy and Medicines Management are operationally line-managed by their respective IHC Directors. This creates a misalignment between professional accountability and operational authority, increasing the risk of gaps in oversight, consistency and strategic alignment across areas.	Lack of clarity. Inconsistent oversight, fragmented decision making, and reduced strategic alignment across areas.	**Agreed Action:** The Health Board recognises the structural tension identified between professional accountability and operational line management arrangements. Actions will prioritise clarifying the professional remit, authority and accountability of the Chief Pharmacist, ensuring alignment between professional leadership responsibilities and organisational reporting arrangements. This will include review of role definition, delegation frameworks and the mechanisms through which professional oversight is exercised across pharmacy services, aligned to the Foundations for the Future programme, including review of organisational structures, reporting lines and job descriptions to ensure alignment with the Welsh Government expectations arising from the Independent Review of Clinical Pharmacy Services in NHS Wales hospitals. These challenges are recognised as reflecting wider organisational complexity in reporting and governance arrangements, rather than issues specific to pharmacy services. In strengthening these arrangements, the Health Board will ensure that the Chief Pharmacist role is supported within a clear and consistent corporate governance and assurance framework. This will align with the emerging Operational Governance Framework, which will define governance tiers, decision-making responsibilities and escalation routes across service and corporate levels, providing clarity on how professional accountability is exercised within operational structures. The GPhC Standards for Chief Pharmacists will be considered alongside the GPhC standards for registered pharmacy premises (as relevant benchmark) and the Royal College of Pharmacy professional standards for hospital pharmacy services, ensuring that leadership accountability is informed by a broader view of service quality, safety and performance. This approach will support a clearer line of sight between service performance, leadership accountability and organisational culture, ensuring the Chief Pharmacist role is both clearly defined and effectively exercised in practice. Immediate actions have also been taken to strengthen oversight and coordination, including the establishment of a formal Pharmacy & Medicines Management Oversight Group (PMMOG). This has been introduced with agreed Terms of Reference, with an initial meeting already held as a soft launch, and is now

			established as a regular monthly forum to provide structured oversight of pharmacy quality, safety, performance and improvement activity. Oversight will operate through: • the Pharmacy & Medicines Management Oversight Group (PMMOG) for pharmacy-specific quality performance and assurance to the Executive Medical Director, and • the Governance and Regulatory Executive Delivery Group for corporate oversight of regulatory compliance, policy alignment and escalation of risks
			Expected Evidence of Implementation: Consistency between leadership and management structures and formal job descriptions.
		High Priority	**Officer:** Executive Medical Director supported by Corporate Governance **Target Implementation Date:** 31 March 2027 - Immediate actions implemented in May 2026 (including establishment of PMMOG and initial governance arrangements). Review and alignment of organisational structures and job descriptions to be progressed through the Foundations for the Future consultation during Summer 2026, with implementation of revised arrangements phased through 2026/27 and formalised and tested by 31 March 2027.
	Theme: Governance	Control Design	
2	**Leadership Clarity and Accountability** Despite documented leadership structures, operational understanding of these arrangements was limited. 98% of staff knew their Director, yet only 43% understood the Director's responsibilities. While 57% of staff reported fully understanding their own responsibilities, 41% only partially understood them. 36% of respondents did not understand who was accountable for key decisions and actions within their area of work. Free-text feedback highlighted leadership visibility issues and unclear accountability.	Failure to meet GPhC Standards for Chief Pharmacists requirements. Inconsistent decision-making, unclear accountability, and reduced confidence in local leadership arrangements.	**Agreed Action:** The Health Board will strengthen how leadership arrangements are communicated, understood and experienced in practice, recognising that current arrangements are not consistently evident to staff. Immediate actions will be taken to improve leadership visibility and communication, including targeted team briefings, reinforcement of roles and responsibilities, and strengthening of local leadership arrangements, so that expectations are clearly understood and consistently applied in day-to-day practice. This work will align with implementation of revised structures through the Foundations for the Future programme. This will be supported by the development of the Operational Governance Framework, which will provide greater clarity on decision-making responsibilities, delegation and escalation routes, enabling staff to understand how decisions are made and

			where accountability sits within services, and helping to ensure that operational leadership arrangements are applied consistently in practice. Leadership arrangements will be further reinforced through the next PADR cycle and GPhC revalidation processes, ensuring that evidence of leadership, governance and professional accountability is explicitly linked to relevant standards in practice, and that expectations are clearly reflected in individual objectives and professional development. Leadership effectiveness will also be informed by a broader range of assurance, including service performance, staff experience and governance effectiveness, ensuring that leadership clarity is assessed in the context of how services are delivered in practice. Implementation will be delivered on a phased basis, with immediate actions underway and ongoing embedding aligned to organisational and governance development.
			Expected Evidence of Implementation: Updated and clearly communicated leadership and delegation arrangements, supported by published organisational charts and role descriptions, and evidenced through staff communications confirming improved understanding of responsibilities and accountability.
		High Priority	**Officer:** IHC Directors of Pharmacy with support from Chief Pharmacist with **Target Implementation Date:** 31 March 2027 - Immediate actions to be implemented from June 2026 by IHC Pharmacy leadership teams, including team briefings, strengthening of local leadership arrangements and reinforcement of governance and accountability expectations. Further alignment through the next PADR cycle (2026/27) and GPhC revalidation processes, ensuring leadership and professional accountability are evidenced against relevant standards. Progress and impact will be evaluated through consideration of a repeat staff questionnaire in 2027/28.
	Theme: Governance	Control Operation	
3	**Governance, Oversight and Escalation** Staff experiences of governance did not consistently reflect the structured pathways described by the Directors. While most staff recognised escalation routes, 20% did not understand how to escalate concerns, and 52% were not confident that raising a	Failure to meet GPhC Standards for Chief Pharmacists requirements.	**Agreed Action:** The Health Board will strengthen the consistency and reliability of governance and escalation arrangements across pharmacy services, ensuring staff are clear on how to raise concerns and confident that these are acted upon appropriately.

	concern would lead to appropriate action and not result in negative consequences for themselves. Furthermore, 75% of staff were not aware of staff protections under the error reporting defences and 30% did not feel safe reporting professional concerns, errors, or near misses without fear of blame. Free-text feedback highlighted irregular meetings, limited feedback after escalation, and unclear expectations, demonstrating that governance arrangements are not reliably embedded in practice.	Inconsistent escalation, delayed or unresolved issues, and reduced governance effectiveness.	This will include clearer guidance on escalation pathways, improved visibility and effectiveness of governance forums, and more consistent feedback on actions taken, supporting a more open and responsive reporting culture. This work will align with the emerging Operational Governance Framework, which will provide clear definition of governance tiers, decision making responsibilities and escalation routes, ensuring that issues are managed and escalated at the appropriate level within the organisation. At a corporate level, oversight of governance, regulatory compliance and escalation of significant risks will be strengthened through the Governance and Regulatory Executive Delivery Group, ensuring that issues arising from services are considered alongside wider organisational risks and statutory requirements. This approach will support a more consistent and structured system for managing concerns, enabling a clearer line of sight from operational issues through to corporate escalation and Board assurance, while reinforcing a culture of openness and continuous learning. This area is recognised as requiring cultural as well as procedural improvement, and therefore progress will be monitored over time rather than through a single implementation milestone. **Expected Evidence of Implementation:** Documented and consistently applied governance processes, evidenced through updated escalation guidance, regular and minuted governance meetings, and demonstrable follow-up and closure of escalated concerns.
		High Priority	**Officer:** IHC Directors of Pharmacy supported by Chief Pharmacist with Corporate Governance
	Theme: Governance	Control Operation	**Target Implementation Date:** 31 March 2027 - Immediate actions to be implemented from June 2026 by IHC Pharmacy Directors, including the consistent operation of regular, minuted local pharmacy governance meetings with clear routes for staff to raise concerns and issues. A specific focus will be placed on closing the loop, ensuring that concerns raised are formally recorded, tracked and communicated back to staff with clear feedback on actions taken

			and outcomes, including through team briefings and governance updates. From June–September 2026, evidence of consistent operation will be demonstrated through regular meeting schedules, documented escalation of issues, and demonstrable feedback to teams on actions taken. This will align with the implementation of the Operational Governance Framework and strengthening of the Corporate Clinical Governance Framework, ensuring clear expectations for escalation, decision-making and quality reporting. Progress and impact will be formally evaluated through considering a repeat staff questionnaire in 2027/28.
4	**SOP Accessibility, Delegation and Workforce Pressures** Despite documented SOP systems in both West and Central (East evidence comprised of an index of available local area SOPs and copies of Health Board-wide SOPs), 28% of staff reported difficulty locating up-to-date SOPs. Delegation clarity also remained weak, with 49% of staff not understanding their level of authority when tasks were delegated. 40% of staff did not feel confident when required to take on additional or extended responsibilities within their role, and 60% reported that they did not receive appropriate support (i.e. guidance, supervision, training) when assuming additional responsibilities. Free-text responses described significant workforce pressures, including understaffing, increased workload, and disruption during the EPMA rollout, which affected the consistency of process compliance and staff confidence in governance arrangements.	Failure to meet GPhC Standards for Chief Pharmacists requirements. Risk of inconsistent SOP compliance Unclear delegation boundaries increasing the likelihood of errors or delays. Operational strain from workload and staffing pressures impacting service reliability.	**Agreed Action:** The Health Board recognises the variability in staff ability to access SOPs and understand delegation arrangements, particularly in the context of operational pressures and service change (including EPMA implementation). Actions will focus on: • Reviewing and rationalising SOP governance arrangements to ensure clarity of ownership, accessibility and currency across all areas. • Strengthening delegation frameworks, ensuring that expectations, authority and responsibilities are clearly communicated and supported. • Aligning SOP and delegation improvements with digital developments (including EPMA) to ensure processes are practical and embedded in workflows. • Considering workforce capacity, capability and support requirements through existing workforce planning processes and the FFTF programme, recognising that workforce pressures are a contributory factor to the issues identified. Improvements will take account of workforce pressures and service delivery challenges, ensuring that SOP and delegation arrangements are practical, supported and sustainable within operational settings. This approach will strengthen the reliability of day to day processes and reduce variation in practice, supporting safer and

			more consistent service delivery across the region rather than silo arrangements. Given the interdependencies with workforce, digital systems and organisational change, improvements will be prioritised based on risk and delivered in phases.
			Expected Evidence of Implementation: Accessible and up-to-date SOPs, clearly communicated delegation arrangements, and documentation demonstrating that staff can reliably access required procedures and understand their authority levels during routine operational activity.
		High Priority	**Officer:** IHC Directors of Pharmacy with support from Chief Pharmacist Office **Target Implementation Date:** 31 March 2027 - Phased improvements through 2026/27, with prioritisation based on risk and service needs. Immediate Task & Finish Groups to be implemented to unblock ePMA dispensary workflow and optimise clinical pharmacy prioritisation and actions identified implemented from 1 August 2026.
	Theme: Governance	Control Operation	

Objective 2: Effective processes are in place to monitor compliance, identify gaps or risks, and manage improvement actions. Where deficiencies are identified, corrective actions are implemented, tracked and reviewed to support continuous improvement and patient safety.	**Limited**

Directors described the use of action logs, risk registers, incident reporting systems (Datix), incident trackers, and pharmacy governance and safety forums, including management / leadership team meetings, patient safety, quality and risk groups, workforce, people and culture groups, finance and performance groups, and operational groups, to track issues, monitor progress, and escalate concerns to relevant IHC-wide oversight forums. Evidence including meeting terms of reference, agendas, minutes, action logs, risk registers, incident reports, and (one) escalation report were provided for review. However, we were unable to fully verify the robustness of established processes or the level of scrutiny applied within all forums from the evidence provided.

Directors confirmed that there is no dedicated tracker to manage improvement actions arising from external regulatory bodies. The Central area Director advised that pharmacy-related actions are typically included as part of broader inspections or reviews (e.g. the HIW inspection of Ysbyty Glan Clwyd Emergency Department). In such instances, the overall action plan is managed by relevant service leads and pharmacy feed into this, providing updates on the implementation of pharmacy related actions. The West area Director described an instance whereby a HIW inspection including the medicines management area had been undertaken in a mental health community hospital, and the resulting action plan was implemented without the Directors oversight - in response a single-point improvement-action tracker is now being implemented to strengthen oversight in the West. Information from the East area Director was limited to, "*Multiple internal trackers are used depending on area/lead*". A

standalone Wholesale Dealer's Authorisation (WDA) MHRA Inspection Action Plan was provided for review, however it's unclear how implementation / delivery was tracked and managed.

Evidence such as incident trackers confirmed that incident-level actions are monitored and reviewed through established governance and safety forums, providing assurance of operational oversight. However, arrangements for evaluating the impact of completed actions remain under-developed. While incident and near-miss data are routinely monitored, none of the areas provided evidence of a systematic or routine post-implementation review process demonstrating sustained improvement.

Assurance reporting to the Health Board Chief Pharmacist is not routinely undertaken and occurs informally or on request, limiting corporate visibility of progress, risks and the effectiveness of implemented improvement actions.

Overall, while systems and processes are in place to support compliance monitoring and risk identification, gaps in structured improvement-action tracking, limited demonstration of impact evaluation, and inconsistent assurance reporting limit the effectiveness of current arrangements.

Key Findings		Risk & Impact	Agreed Management Action
5	**Monitoring Improvement Actions** Pharmacy Services have established processes for recording risks and incidents, and all areas use Datix, governance meetings and action logs to support monitoring. However, arrangements for managing improvement actions lack consistency and maturity. Directors confirmed that none of the areas have a dedicated tracker for managing improvement actions arising from external regulatory bodies – though West area reported that a single-point tracker is now being implemented. Central area advised that pharmacy-related regulatory actions are typically included within broader service action plans that are managed and overseen by the relevant service leads. Whilst the process for managing Pharmacy specific improvement plans was described, the Director advised that there were no recent pharmacy-specific regulatory actions, therefore processes are untested. It remains unclear whether future regulatory recommendations would be systematically captured and monitored through the established processes.	Regulatory actions missed due to absence of dedicated tracker. Inconsistent oversight and fragmented monitoring.	**Agreed Action:** The Health Board will strengthen the consistency and visibility of arrangements for monitoring pharmacy improvement and regulatory actions, ensuring a clearer and more reliable process for capturing, tracking and escalating actions. Immediate actions are being implemented from June 2026 to improve visibility of pharmacy regulatory and improvement actions, including the use of existing local tracking processes and the establishment of a baseline position across IHC areas. This will include the development of a coherent framework for managing improvement actions, underpinned when ready by the Health Board's Quality Management System (QMS), to provide a structured, consistent and auditable approach to recording, tracking and reporting improvement activity across pharmacy services. The Pharmacy & Medicines Management Oversight Group (PMMOG) will act as the primary forum for early escalation, oversight and coordination of pharmacy-related improvement actions and emerging risks, ensuring that issues are identified and addressed promptly at an operational level. This work will align with the emerging Operational Governance Framework and strengthening of the Corporate Clinical Governance Framework, supporting clearer expectations for monitoring, escalation and reporting of improvement actions across governance tiers.

			At a corporate level, oversight of regulatory compliance and associated actions will be strengthened through the Governance and Regulatory Executive Delivery Group, ensuring that pharmacy-related actions are considered alongside wider organisational regulatory requirements and risks. This approach will provide a clearer line of sight between identified issues, improvement actions and organisational oversight, and will ensure that actions are not only tracked but are subject to appropriate review and escalation where required.
			Expected Evidence of Implementation: Implementation of a Health Board-wide / IHC area tracker to support the management, oversight, and delivery of all Pharmacy regulatory improvement actions. Evidence of monitoring and scrutiny at relevant senior governance forums.
		High Priority	**Officer:** IHC Directors of Pharmacy with support from Chief Pharmacist Office **Target Implementation Date:** 31 March 2027 - Immediate actions implemented from June 2026, including establishment of baseline tracking arrangements across IHC pharmacy teams. Implementation of a QMS-aligned framework from September 2026 (dependent on readiness), with IHC Pharmacy Directors prioritising its use for monitoring improvement actions, supported by evidence of consistent recording, escalation and review through PMMOG and routine governance meetings. Further embedding through 2026/27, with arrangements formalised by 31 March 2027.
	Theme: Quality, Safety & Patient Experience	Control Design	
6	**Post-Implementation Review and Impact Assessment** Areas demonstrated that incident and near-miss data are routinely reviewed; however, the audit found no consistently applied framework for evaluating whether implemented improvement actions have resulted in measurable or sustained improvements to patient safety. Central acknowledged that some monitoring occurs informally (e.g., spot checks, trend reviews) but is "not formally documented," and a planned retrospective audit had not yet been undertaken. The West area confirmed that its post-implementation review arrangements are "limited," with KPI development not scheduled until April 2026. No information was provided by East area.	Unverified improvement effectiveness due to absence of a structured post-implementation review. Limited assurance where monitoring is informal or undocumented. Potential for repeated issues and	**Agreed Action:** Building on strengthened arrangements for tracking improvement actions (Finding 5), the Health Board will strengthen the approach to post-implementation review of pharmacy related improvement actions, ensuring that actions arising from medication incidents, regulatory findings and medicines governance processes are systematically evaluated for their effectiveness and sustainability. This will include the development of a proportionate and consistent framework to assess whether actions have resulted in measurable improvement in medication safety, medicines governance and service delivery, rather than relying solely on completion of actions.

		delayed identification of patient-safety impact.	This work will be underpinned by the Health Board's Quality Management System (QMS), to support a more systematic and consistent approach to recording, monitoring and evaluating the impact of improvement actions, and to strengthen continuous quality improvement across pharmacy services. This work will align with the emerging Operational Governance Framework, ensuring that evaluation of improvement is embedded within routine pharmacy governance arrangements, with clear expectations for review, learning and escalation through defined governance tiers. Evaluation will be informed by a triangulated range of pharmacy specific evidence, including: • medication incident and near-miss trends (e.g Datix) • audit and regulatory findings (e.g MHRA, HIW or internal review) • medicines safety indicators and service performance data • feedback from pharmacy and multidisciplinary teams Learning and outcomes from post-implementation review will be used to inform ongoing service improvement and reduce the risk of recurrence. At a corporate level, significant themes relating to regulatory compliance and patient safety will be escalated through the Governance and Regulatory Executive Delivery Group, ensuring alignment with wider organisational governance and risk.
			Expected Evidence of Implementation: Documented and consistently applied post-implementation review process, demonstrating that improvement actions have resulted in measurable and sustained patient-safety benefits / outcomes.
		High Priority	**Officer:** IHC Directors of Pharmacy with support from Chief Pharmacist Office and Executive Medical Director/Performance team
	Theme: Quality, Safety & Patient Experience	Control Design	**Target Implementation Date:** 31 March 2027 - Framework development during 2026/27 with gradual embedding of the QMS into routine governance processes from September 2026.

7	**Assurance Reporting to the Health Board Chief Pharmacist** We found that formal assurance reporting to the Health Board Chief Pharmacist is not routinely undertaken by Area Pharmacy Services, though Directors confirmed that updates are provided when requested, typically via email or informal discussion. This limits the Chief Pharmacist's oversight of improvement actions, risk mitigation, and compliance monitoring activities, and reduces the Board-level assurance available on the effectiveness and timeliness of corrective actions. It is unclear how this will improve through implementation of the Foundations for the Future major change programme.	Reduced oversight due to lack of routine assurance reporting. Limited visibility of risks for the Chief Pharmacist at corporate level. Weaker assurance over progress and effectiveness of improvement actions. Potential delays or gaps in addressing compliance and safety issues.	**Agreed Action:** To support strengthened monitoring and evaluation (Findings 5 and 6), the Health Board acknowledges the need to strengthen routine, structured assurance reporting to the Chief Pharmacist to support corporate oversight and Board-level assurance. This will include development of a clear and proportionate assurance framework, ensuring more consistent reporting from services and a stronger line of sight between operational pharmacy practice (including medication safety, incidents and governance activity) and corporate oversight. This work will align with the emerging Operational Governance Framework, which will clarify reporting arrangements, governance tiers and escalation routes, ensuring that pharmacy assurance information is captured consistently and escalated through the appropriate governance structures. At a corporate level, pharmacy related regulatory assurance, including themes from inspections, incidents and compliance activity, will be aligned to the Governance and Regulatory Executive Delivery Group, ensuring that medicines governance is considered alongside wider organisational statutory and regulatory requirements. This approach will strengthen Board-level assurance, providing a clearer and more consistent understanding of pharmacy risks, performance and improvement, and supporting more effective oversight of patient safety and quality. **Expected Evidence of Implementation:** Routine, documented assurance-reporting process to the Health Board Chief Pharmacist, supported by regular written updates demonstrating oversight of risks, improvement actions and compliance activity.
		High Priority	**Officer:** Chief Pharmacist with IHC Directors of Pharmacy supported by Corporate Governance **Target Implementation Date:** 31 March 2027 - Implementation of structured reporting during 2026/27, aligned to PMMOG maturity and wider governance changes under FFTF. Pharmacy & Medicines Management Quality report to be submitted to the Quality, Safety and Experience Committee in 2027.
	Theme: Reporting	Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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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.

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.

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Challenged Services – Improvement plans

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-30
Fieldwork	February 2026 – April 2026
Executive Sign Off	June 2026
Audit Committee	August 2026
Executive Lead	Paolo Tardivel Interim Executive Director of Transformation and Strategic Planning
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Patrick Williams, Principal Auditor

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the improvement plans for challenged services, and the evidence in place to support delivery of actions.

Overview

While improvement plans exist for all challenged services, we found content and presentation varied; slippage against original milestones with no evident refresh of these for some and gaps in expected assurance reporting.

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

- There is inconsistency in the depth of improvement plans across services. While some services have developed comprehensive plans, others remain high level.
- A number of actions across services had not been delivered within the planned timescales with no update on refreshed timescales evident.
- One challenged service has clinical leadership in place only within the East area, with no pan-BCUHB clinical leadership arrangement established.
- The audit could not confirm that consistent local governance arrangements are operating effectively, with some services holding meetings irregularly or standing them down.
- In accordance with the terms of reference for the Strategic Planning and Service Change Group, the Executive Committee does not appear to be receiving assurance following each meeting.

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

Scope & Assurance Summary

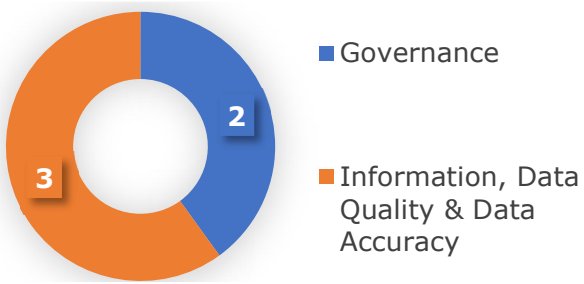
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There are detailed improvement plans in place for each challenged service, which address WG requirements for de-escalation.	1,2	**Limited**
2	There is evidence available to support implementation and embedding of the actions that have been completed.	3	**Reasonable**
3	There is appropriate oversight and scrutiny of challenged services, and the progress of improvement plans/de-escalation criteria, through the services, Executives and Board, with appropriate reporting to Welsh Government.	4,5	**Limited**

Management Actions

4 High Priority

1 Medium Priority

Themes



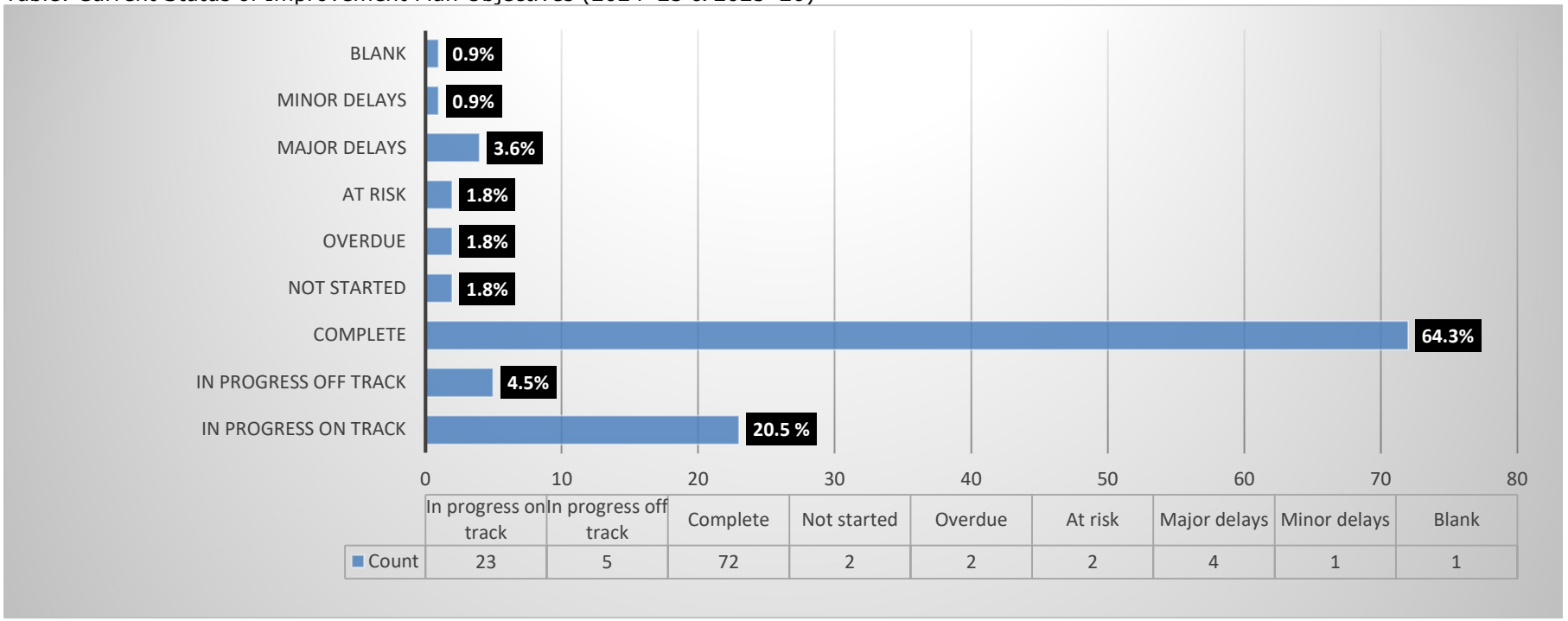
Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

The table summarises the current progress of the aims and objectives for the 2024–25 and 2025–26 high level improvement plans.

Table: Current Status of Improvement Plan Objectives (2024–25 & 2025–26)



Findings & Agreed Action Plan

Objective 1: There are detailed improvement plans in place for each challenged service, which address WG requirements for de-escalation.	**Limited**

Within Betsi Cadwaladr University Health Board (Health Board), the term *challenged services* refers to clinical areas that are failing to meet established standards and continue to demonstrate significant issues relating to quality, patient safety, performance, or long-term sustainability. These services are formally identified by both the Health Board and the Welsh Government as requiring enhanced oversight and targeted improvement measures to ensure the delivery of safe, consistent, and timely care for the population of North Wales. The de-escalation criteria are that given to the Health Board by the Welsh Government and is generic to all services.

All eight Challenged Services provided Improvement Plans, there is variation in the level of detail presented across the service plans where some services have deviated from the standard templates developed to ensure consistency in information captured, reflecting the differing stages and maturity within each service. The Vascular and Urology plans are more advanced, offering multi-tab documentation that outlines objectives, delivery priorities, leads, current status, delivery confidence, and the drivers influencing progress. This provides a strong basis for demonstrating progress against the de-escalation criteria. As the plans continue to develop, there would be value in aligning them more closely with the level of detail demonstrated in the Vascular and Urology plans.

Several actions within the plans remain incomplete for the year 2025/26. Vascular Services had 27 actions for the year 2025/26 with 14 actions missing delivery in quarter one to three (1-3), including those classified as in progress on track. Similarly, ophthalmology has four actions experiencing major delays e.g. *Reinstate Pan-BCU Sub-speciality networks to drive continuous improvement and transformation with delivery date of 30 June 2025* and three reported as on track; however, these actions have also failed to meet their agreed delivery dates, and it remains unclear when the steps noted will be addressed

We also noted that the GIRFT recommendations tracker for Orthopaedics recorded a major delay for recommendation 11, relating to development of a work plan; there is no evident implementation date recorded for us to observe how overdue this action is.

A cross-review of the improvement plans for challenged services highlights the collective recurring themes below:

- Workforce Fragility and Recruitment Challenges.
- Specialties highlight long waiting lists, treatment delays, or overdue follow-ups.
- Insufficient Estates, Infrastructure and Operational Capacity.
- Lack of Standardised Model (lacking a unified service model).
- Rising Demand Outstripping Capacity.

We were provided with the named service leads responsible for supporting the improvement plans for each challenged service; however, effective de-escalation requires strong and consistent clinical leadership. The current arrangements vary: some services have a single clinical lead overseeing the whole Health Board, others have a pan Health Board lead and separate clinical leads for the East, Central and West areas. One service has clinical leadership in place only for the East and no pan Health Board oversight, resulting in limited clinical oversight across the remaining areas.

Key Findings		Risk & Impact	Agreed Management Action
1	**Improvement plans – Delivery** A review of progress against agreed action plans found that a number of actions across services had not been delivered within the planned timescales. Scheduled delivery quarters were missed and we are unclear on when these steps are to be achieved In addition, the quality and depth of improvement plans is inconsistent across services. While some services have produced detailed, multi-tab plans that clearly evidence progress against the de-escalation criteria, others remain high-level and lack sufficient detail to fully demonstrate compliance.	There is a risk that inconsistent or insufficiently detailed improvement plans may weaken oversight and delay action on performance issues, potentially prolonging "challenged services" status	**Agreed Action:** Implement and ensure adherence to a standardised improvement plan template based around a Quality Management System (QMS) methodology, including clear milestones, named owners, and delivery dates. Supplement with monthly oversight to track progress and address slippage, ensuring all services produce detailed, evidence-based plans aligned to de-escalation criteria.
			Expected Evidence of Implementation: 1. Revised set of Improvement Plans in a consistent format. 2. Action log from Challenged Services Oversight Group outlining actions to address slippage.
		High Priority	**Officer:** Head of Improvement **Target Implementation Date:** 31 August 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	
2	**Improvement Plans – Clinical Leadership** While named service leads are in place for all Challenged Services, the audit identified inconsistent clinical leadership arrangements that may limit the effectiveness of improvement delivery. Variations in clinical leadership, including one service with clinical leadership only in the East and no pan-Health Board oversight, may result in reduced clinical governance and assurance. Strengthening and standardising clinical leadership arrangements across the Health Board would improve ownership, accountability, and oversight of improvement plans, and better support progress towards de-escalation. We note plastics are a commissioned service.	Where clinical leads are absent or unclear, there is reduced assurance that improvement actions are being informed by appropriate clinical expertise.	**Agreed Action:** Standardise clinical leadership arrangements across Challenged Services by establishing clear, pan-Health Board clinical leadership roles via the implementation of Foundations for the Future.
			Expected Evidence of Implementation: 1. Updated Clinical Leadership structure. 2. Up to date list of all clinical leads currently in post for all Challenged Services and any gaps to have nominated clinical oversight pending implementation of Foundations for the Future.
		High Priority	**Officer:** Executive Medical Director **Target Implementation Date:** 30 September 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 2: There is evidence available to support implementation and embedding of the actions that have been completed.	**Reasonable**

A sample of completed actions across all challenged services was reviewed to determine whether the required measures had been appropriately implemented. For each action sampled, we reviewed supporting evidence to confirm that agreed objectives had been met, changes had been incorporated into routine processes where applicable, and delivery aligned with approved improvement plans. This approach provided assurance over the completion of the improvement actions taken. The sample covered a range of clinical services and improvement themes, including service configuration, workforce development, governance arrangements, infrastructure, and capacity planning.

Testing confirmed that all sampled services except one had implemented their completed improvement actions as intended, supported by sufficient and appropriate evidence demonstrating delivery within agreed timescales. For one service, although the action was recorded as complete, the evidence reviewed showed it was only partially implemented, with progress underway but full delivery not yet achieved.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Implementation of plans** All but one of sampled services have implemented their completed improvement actions as intended, with sufficient evidence demonstrating delivery within agreed timescales. For Orthopaedics, despite the action being recorded as complete, we found that implementation was only partial, with progress evident but full delivery not yet achieved.	Controls may not operate as intended until the improvement action is fully implemented	Strengthen validation and sign-off processes for completed actions by introducing formal completion criteria and assurance checks, ensuring actions are only closed once fully implemented, with targeted follow-up to complete outstanding elements. **Expected Evidence of Implementation:** Evidence Log for completed actions.
		Medium Priority	**Officer:** Chief Operating Officer **Target Implementation Date:** 31 August 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: There is appropriate oversight and scrutiny of challenged services, and the progress of improvement plans/de-escalation criteria, through the services, Executives and Board, with appropriate reporting to Welsh Government.	**Limited**

Key issues reports are submitted to the Health Board, evidencing that challenged service updates are reported to the Quality, Safety & Experience (QSE) Committee. In addition, the QSE receives regular, structured challenged services update reports for all of the eight Challenged Services, addressing areas including:

- An executive summary.
- Shared improvement themes.
- Service-specific issues.
- Progress against actions.
- The impact of identified issues.

We note that within the Challenged Services update report to the QSE, relating to ophthalmology, the workforce and quality/standards/practice areas are rated green, despite the accompanying plans identifying actions that are subject to major delays (rated red).

The Strategic Planning and Service Change Group, chaired by the Chief Executive, receives progress reports on the Challenged Services, forming another layer of executive oversight. This report provides a summary of the services, outlining overall progress through RAG rating on six domains alongside issues, and areas requiring escalation from services.

The terms of reference for the Strategic Planning and Service Change Group (SPSCG) appendix 2 states that the Strategic Planning and Service Change Group reports to the Executive Committee. Our review of the Executive Committee minutes identified that the Strategic Planning and Service Change Group AAA Report was presented at meetings held on 25 June 2025, 14 January 2026, and 22 April 2026.

In addition, a newly established subgroup, *Challenged Services Oversight Group*, chaired by the Chief Operating Officer, has been created to strengthen scrutiny and support the development of robust, fit-for-purpose improvement plans.

While the group does not issue formal minutes, an action-tracking log has been provided as evidence of its activity and monitoring arrangements, We note that two actions remain outstanding, both originally due for completion on 16 February 2026; however, as the scheduled meeting was cancelled, these actions will now be reviewed at the rescheduled meeting on 30 March 2026 We can confirm that the actions were reviewed and additional steps have been taken; however, two actions remain outstanding. Evidence was provided of Welsh Government Touchpoint meetings that provide formal oversight between Welsh Government (WG) and the Health Board, reviewing performance across all eight Challenged Services. Held quarterly, these meetings enable WG to assess progress, identify ongoing risks, and determine whether services are ready for potential de-escalation from Special Measures.

We requested evidence of the local governance arrangements in place across the eight challenged services. Responses were received from all of the services. Seven provided details of steering groups or equivalent oversight arrangements. Orthopaedics advised that there is currently no specific steering group in place; however, the establishment of a specific steering group is under consideration. Evidence obtained from meetings identified that, within certain services, meetings were not undertaken regularly, with instances where meetings had been stood down.

Clinical lead representation could not be confirmed for two services, limiting assurance that appropriate clinical oversight, input, and challenge are in place.

Key Findings		Risk & Impact	Agreed Management Action
4	**Challenged Service – Governance arrangements** Although services have established local meetings, there is inconsistency in some services, with irregular meetings and one service (Orthopaedics) without a formal steering group in place. Strengthening the consistency and regularity of local governance arrangements enhances assurance over the	There is a risk that key issues are not identified, escalated, or addressed in a timely manner due to lack of effective	**Agreed Action:** 1. Implement consistent local governance arrangements across all services, including establishment of formal steering groups with defined membership and regular meeting schedules, and mandate clinical representation to strengthen oversight, raise visibility and improve management of risks and issues.

	effective delivery of improvement activity across all Challenged Services. Clinical lead representation could not be verified for two services, limiting confidence that clinical leadership, oversight, and challenge are in place.	governance and clinical leadership oversight.	2. Implement an Operational Governance Framework. **Expected Evidence of Implementation:** 1. Annual Meeting schedule across all services, including agreed membership. 2. Copy of approved Operational Governance Framework.
		High Priority	**Officers:** 1. Chief Operating Officer 2. Associate Director of Governance **Target Implementation Date:** 31 August 2026
	Theme: Governance	Control Operation	
5	**Executive Oversight** The terms of reference for the Strategic Planning and Service Change Group indicates that the Group should report to the Executive Committee after each meeting. A review of the Executive Committee minutes identified that the Strategic Planning and Service Change Group AAA Report was presented at meetings held on 25 June 2025, 14 January 2026, and 22 April 2026. While evidence confirmed that the Strategic Planning and Service Change Group AAA Report has been reported to the Executive Committee, this has occurred intermittently. We note we have been unable to confirm Executive meetings for the months of August 2025 and October 2025.	Executive Committee lacks visibility and oversight of Challenged Services.	**Agreed Action:** 1. Formalise reporting arrangements by ensuring a AAA report is submitted to the Executive Committee following every Strategic Planning and Service Change Group meeting. 2. Update the Terms of Reference for the Strategic Planning and Service Change Group to clarify the cycle of business, outlining that not all topics are covered at every meeting. **Expected Evidence of Implementation:** 1. Copies of AAA reports and Executive Committee agendas demonstrating coverage. 2. Updated Terms of Reference for the Strategic Planning and Service Change Group.
		High Priority	**Officer:** Interim Assistant Director of Health Strategy **Target Implementation Date:** 31 July 2026
	Theme: Governance	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

Nuclear Medicine Consolidation

Final Internal Audit Report

2025/26

Betsi Cadwaladr University UHB

Unsatisfactory Assurance

Contents

Review Reference	BCU-SSU-2526-45
Fieldwork	February - April 2026
Executive Sign Off	27th July 2026
Audit Committee	18th August 2026
Executive Lead	Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Audit Team	Huw Richards, Head of Internal Audit
	Murray Gard, Deputy Head of Internal Audit
	Paul Stocker, Audit Manager

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This audit reviewed the delivery and management arrangements in place to progress the Nuclear Medicine Consolidation project during the Full Business Case (FBC) stage. The audit was commissioned in accordance with the agreed Integrated Audit Plan provided within the approved Outline Business Case (OBC) and was the first audit of the project. Further audits are planned within the updated Integrated Audit Plan provided to management for inclusion within the FBC.

Overview

Following Welsh Government approval of the OBC in June 2025, development of the FBC identified increased revenue costs driven by revised activity assumptions and commissioning arrangements. The updated model indicates an initial funding shortfall of c.£255k in 2028/29, improving to break-even by 2033/34 as activity levels increase and economies of scale are achieved.

Cost pressures reflect growth in PET-CT activity commissioned via NHS Wales Joint Commissioning Committee (NWJCC), with a cost-per-case funding model resulting in higher expenditure for the Health Board irrespective of provider. Revised, lower early-year demand assumptions have delayed efficiency gains and increased unit costs compared to the OBC, with tariff and funding discussions ongoing as part of Welsh Government scrutiny.

Notwithstanding these pressures, the UHB progressed the FBC, which was subsequently approved by the UHB Board in January 2026, with the proviso that the issue of the anticipated revenue shortfall would be addressed via planned discussion with NWJCC scheduled for February 2026. This approval reaffirmed the project's strategic importance and its alignment with organisational priorities.

The FBC was submitted to WG in January 2026, with an anticipated construction start date of March 2026. Following submission, the UHB was required to respond to a series of scrutiny questions raised by the Welsh Government and its agents. However, the UHB failed to resolve and respond to all of the WG scrutiny questions (key being the increased revenue implications). This effectively meant that the UHB was unable to complete the WG scrutiny process ahead of the pre-election period. As a result, the project did not secure funding within the current approval cycle and is now subject to delay.

Any delay in progressing the scheme may result in increased capital costs due to inflationary pressures and could necessitate elements of the business case being revisited. In addition, future funding decisions will be dependent on the priorities of the incoming government.

In summary, while the project continues to be regarded as strategically important and is supported in principle, the timing of key approvals and unresolved financial considerations have impacted the UHB's ability to progress funding at this stage, therefore increasing the risk and uncertainty on the successful delivery of the scheme at this point in time. We have therefore concluded **unsatisfactory assurance** at the time of the current audit.

The significant matters requiring management attention include:

- determination whether the project is economically viable given revenue and capital cost pressures;
- the timely reporting to the Board/Sub-Committees re: the risk of missed external funding opportunities and potential adverse impact on delivery of this strategically important project;
- appointment of Project Director and formalised acceptance of accountabilities.
- appointment of Cost Adviser and development of ongoing cost reporting; and
- resolution of difficulties that have delayed recruitment of the Cost Adviser and NEC Supervisor.

A number of the above issues align with those identified in the previous Llandudno Orthopaedic Audit and were also highlighted within the recently issued Capital Governance Advisory Review. It is recognised that these matters will be addressed through the wider actions being developed by the UHB Executive Team in response to the Advisory Review.

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	**Project Performance:** Consideration of performance against project objectives (e.g. time, cost, benefits, critical success factors etc.).	1,5	**Unsatisfactory**
2	**Governance:** To assess whether the project's governance framework is clearly defined, effectively operated, and provides robust management and control by reviewing programme management arrangements, the adequacy and effectiveness of workstreams, the operation of approval processes, and the project's overall readiness to proceed.	2,3	**Limited**
3	**Financial:** To evaluate whether the project's financial management arrangements are robust and well-governed by reviewing the adequacy of financial approvals and budget-setting processes; the effectiveness of financial monitoring and cost control (including use of Project Bank Accounts); the management of contingency and cost-related risks; and the arrangements for ongoing tracking and reporting of project costs.	4,5	**Unsatisfactory**
4	**Technical:** To evaluate whether the project's technical management is robust and compliant by assessing programme management arrangements, the determination and validation of target and actual costs, the adequacy of tender evaluations and contractual arrangements, the quality and completeness of site surveys, and compliance with acceptable framework conditions.	-	**Reasonable**
5	**Advisers:** To provide confirmation that advisers to the project were procured fairly and in line with procurement rules through review of procurement route for each adviser. Assurance that advisers were appropriately appointed with defined forms of contracts.	6	**Reasonable**
6	**Design:** To assess whether the project's design at Full Business Case stage is robust, affordable, and compliant with required standards by evaluating the management of derogations, the impact of value engineering and affordability decisions, adherence to design warranties, the adequacy of design sign-off and approval processes, and the effectiveness of change-management arrangements.		**Substantial**
7	**Planning:** To determine whether planning activities for the project are effective and compliant by assessing the status and management of planning approvals, the delivery of planning conditions and requirements, the adequacy of communication and coordination processes, and the effectiveness of arrangements for managing objections.	7	**Reasonable**
8	**Information:** To assess whether information management systems supporting the capital project are reliable, effective, and fit for purpose by evaluating the adequacy of processes, controls, and systems used to store, manage, and share project information		**Substantial**

Management Actions

3	4
High Priority	Medium Priority

Themes

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Nuclear Medicine - At a Glance

The current Nuclear Medicine service is delivered across three acute hospital sites, each equipped with a Gamma Camera, alongside a mobile PET-CT unit operating on a part-time basis for three days per week at Wrexham Maelor Hospital.

The proposed project provides an opportunity to enhance service quality, improve operational resilience, and achieve greater cost efficiency. The preferred option is the consolidation of services into a single Centre of Excellence for Nuclear Medicine at Ysbyty Glan Clwyd Hospital. The proposed Centre would house two Gamma Cameras and a permanently installed PET-CT scanner.

As part of this project Gamma Cameras procured in 2022 for Wrexham Maelor Hospital and 2025 for Ysbyty Gwynedd – would be relocated as per the proposed service reconfiguration.

The FBC had been prepared and had been progressed within pre-defined timescales through internal governance and approval processes culminating in Board Approval on the 29th of January 2026 and submission the following day (30th January 2026) to Welsh Government (WG). Following this the Project Board Members and Project Team worked to address the questions posed as part of the scrutiny undertaken by WG. At the time of reporting a number of these remained open (inc. revenue assumptions, tender validity etc). The fundamental issue around the shortfall in revenue funding implications which had been communicated throughout the internal FBC approval process was not resolved by the UHB leadership before the WG closed down as part of the pre-election process.

Findings & Agreed Action Plan

Objective 1: Project Performance — Unsatisfactory

Overview / Summary of Observations

Time

Milestone Activity	OBC Target Dates (source OBC)	FBC Target Dates (source FBC)
FBC submission to WG	December 2025	January 2026
WG approval of FBC	December 2025 - March 2026	April 2026
Commence construction	March2026	May 2026
Construction completion	February 2027	August 2027
Facility operational	May 2027	September 2027

The project has experienced delays against the key milestones established within the OBC.

The delay in progressing the project has been primarily attributed to unresolved affordability considerations, which resulted in the UHB missing the current funding window. This has introduced uncertainty in relation to future funding approval, alongside risks of further delay to project delivery and benefits realisation. In addition, extended timescales increase exposure to inflationary pressures and create a risk that assumptions underpinning the FBC may require revision. There is also a risk of diminished value arising from resources already invested, together with a potential adverse impact on stakeholder confidence should delays continue.

Cost

The OBC (OBC), developed in 2024, identified anticipated capital funding requirements of £19.2 million. At FBC stage, the total project cost has reduced to £17.1 million, remaining within the overall £20 million funding envelope agreed with WG. The capital cost position had been reviewed and validated by the UHB's appointed Cost Advisers, providing assurance that the scheme was deliverable within the approved capital limits.

Notwithstanding the favourable capital position, key issues would need to be resolved:

- the revised revenue assumptions identified at the FBC stage indicated reduced patient throughput relative to earlier forecasts. This has resulted in a projected net revenue pressure of approximately £255k in the first year of operation, with ongoing financial impact extending to 2035.
- Recognising the delays in addressing scrutiny questions associated with the revenue shortfall, the Contractor's submitted prices were only fixed till the 31st March 2026 and the tender offer will therefore be reviewed and resubmitted with an inevitable impact on the capital cost assumptions and the potential financial viability of the scheme.

In the context of the of the UHB's current financial position and the requirement to achieve financial balance, these projected revenue pressures have contributed to a pause in the progression of the scheme.

Quality

At FBC stage, the project demonstrated an appropriate level of design development. Evidence was reviewed confirming that clinical and technical requirements had been incorporated into the emerging design. Stakeholder engagement had been demonstrated with relevant clinical and operational groups, and feedback had been used to inform design evolution. At the time of the current review the technical design was being evaluated as part of the wider scrutiny of the FBC.

Conclusion

Although the project demonstrates appropriate design development informed by stakeholder engagement, delays arising from the unresolved revenue affordability have led to significant slippage against key milestones, a pause in progression, and ultimately uncertainty over the delivery of the scheme resulting in **unsatisfactory assurance** over project performance to date.

Key Findings: Project Performance		Risk & Impact	Agreed Management Action
1	The NHS Infrastructure Investment Guidance states that "*The indicative timescale for the initial review and feedback by the Welsh Government of business cases is a minimum of 30 working days (it should be noted, however, that in most cases business cases take several months to go through the scrutiny and feedback process).*" The FBC was approved by the UHB and submitted to WG on the 30th January 2026. The scrutiny questions were received from WG on the 4th March 2026 (23 working days). The completed scrutiny grid was returned by the UHB to WG on the 19th March 2026 with a number of key issues remaining open e.g. recurring revenue costs, tender validity etc. This effectively meant that the UHB was unable to complete the WG scrutiny process ahead of the pre-election period. As a	The lack of timely visibility by the Board/Sub-Committees, increases the risk of missed external funding opportunities and potential adverse impact on delivery of this strategically important project.	**Agreed Action:** The following action was completed prior to issue of the Report; The Project Manager's Highlight Report presented to the joint Project Team/Board meeting on 27th April 2026, moved the project status from an amber to a red status and noted that `*Initial responses to the essential queries were returned to Welsh Government on 19th March 2026. The query requesting assurance on the revenue implications was in draft form and not agreed as yet at DoF level,* ` and made multiple references to the delay to the programme and risk increases including to the current operational service. The risk associated with FBC approval was also increased to its highest possible score of 25. The delay was also reported to the Capital Development Team meeting held on the 8th April 2026 and noted in those minutes.

	result, the project did not secure funding within the current approval cycle and is now subject to delay. A review of minutes and supporting papers from relevant governance and oversight committees (e.g Board and/or its Sub-Committees) identified no evidence that the delay, or the associated risks and implications for funding of project delivery, were reported, discussed, or formally escalated. This indicates that controls in place to monitor and report key capital programme milestones were not operating effectively, limiting timely visibility of a critical issue and reducing the ability of the Board and Sub-Committees to provide oversight or intervene in relation to this strategically important project. *Note: Issues associated with the Health Board's capital reporting and escalation arrangements have been highlighted within the Capital Governance Advisory Review.*		The delay was again reported to the Project Board on the 6th July 2026 and subsequently a letter escalating the issues has been issued by the Project Director to the SRO. The SRO is continuing to liaise with the Directors of Finance and Corporate Governance in relation to the revenue approval assurance. A formal update on the change in position from the Board meeting on 29th January 2026 is in draft form and under review prior to sharing with the Executive Team. This update provides the current status, notes that the key risks associated with the business case needs remain and provides the background along with an assessment and series of recommendations. **Expected Evidence of Implementation:** • Copy of the update report and minutes of the Executive Team meeting. • Copy of the evidence or assurance associated with the revenue within the FBC scrutiny grid response after submission to WG. • Copy of subsequent Project Manager Highlight reports and all documentation which evidence the progress associated with progressing the recommendations set out within the update report.
		High Priority	**Officer: SRO** **Target Implementation Date:** 28th August 2026
	Theme: Governance	Control Operation	

Objective 2: Governance	Limited

Overview / Summary of Observations

Governance arrangements had been defined within the OBC and updated within the FBC, as supported by a detailed Project Execution Plan (PEP). Key roles were defined, including the Senior Responsible Officer and Project Director. External advisers were appointed to provide project management support, with cost advisory services in the process of appointment at the time of the audit.

However, the assignment of key roles differed at the PEP, noting that this is the key tool in defining project controls. This can cause ambiguity over accountability and reduced assurance that the project is being managed in line with the approved / intended governance structure.

The governance structure provides for a Project Team and defined workstreams with oversight by a Project Board reporting to WG via the Executive Team and Senior Responsible Owner. In practice, the Project Board and Project Team have operated as a combined forum, which may reduce the separation between delivery and oversight / scrutiny / independent challenge. This requires clear terms of reference and documentation of scrutiny and decisions to ensure the maintenance of effective controls.

The audit identified inconsistent attendance by the Project Director at Project Board meetings, with representation often provided by a deputy, and an impending retirement creating a further risk to continuity of leadership.

In addition, at a strategic level of reporting, the delay in addressing the WG scrutiny question around revenue funding was not formally escalated to the Board or relevant Sub-Committees until the Board meeting of the 29th March 2026, by which time the window of opportunity had closed due to WG shutdown for purdah.

	Key Findings: Governance	Risk & Impact	Agreed Management Action
2	The Project Director has not consistently attended the Project Board meetings, with representation typically provided by a deputy. Whilst this has supported continuity, it may have limited the level of direct senior oversight and engagement at key stages of decision-making. In addition, the planned retirement of the Project Director introduces a further risk to continuity of leadership at a critical point in the project. Without appropriate arrangements, this may affect the continuity of knowledge and established stakeholder relationships. Overall, this highlights the importance of maintaining clear governance arrangements and ensuring a well-planned handover to support continued oversight, momentum, and delivery confidence.	Potential risk to continuity of governance and oversight. Timeliness of decision making, clarity of direction, and stakeholder confidence, with potential implications for project momentum and delivery if not effectively managed.	**Agreed Action:** Following the retirement of the previous Project Director the deputy chair of the Project Board has now been appointed as the Project Director, and this will be formalised within an appointment letter. **Expected Evidence of Implementation:** Copy of appointment letter with countersignature of acceptance.

	Note: Issues associated with the Health Board's capital reporting and escalation arrangements have been highlighted within the Capital Governance Advisory Review.		
		High Priority	**Officer:** SRO
	Theme: Governance	Control Operation	**Target Implementation Date:** 31st July 2026
3	The Project Execution Plan (PEP) defines a clear two-tier governance structure, with the Project Board providing strategic direction, oversight and challenge, and the Project Team responsible for operational delivery. However, in practice, these groups were operating as a single combined forum to support attendance. While pragmatic, this arrangement departs from the approved governance framework and reduces the separation between oversight and delivery functions. of project governance and assurance. Effective separation between oversight and delivery is a key element of timely and robust decision-making. The current combined governance arrangements may have limited this separation, potentially impacting the pace of escalation, challenge, and approval, and thereby contributing to delays in progressing the Full Business Case. The Project Director has advised that this model was to be reconfigured once the next stage of the project was initiated, understanding that the construction stage would require enhanced level of scrutiny and oversight.	Potential risk that independent challenge and scrutiny are diminished, accountability for decisions is less clearly defined, and there is an increased risk that issues are not subject to appropriate escalation or objective review.	**Agreed Action:** The existing arrangements to support attendance and reduce impact on clinical staff is for the Project Team meeting with wider workstream attendance to immediately precede the Project Board meeting with limited representation in line with the Procedure Manual for Managing Capital Projects. Decisions required from the Project Team meeting are taken forward to the later Project Board meeting along with any other matters. This is reflected in the notes of these meetings. The proposed actions which are commensurate to the position pre FBC approval are; • Review the Project Team terms of reference including membership Complete the same for the Project Board. • Separate the diary invitations for the 2 meetings. • Amend the PEP to accurately reflect the terms of reference, membership and meeting arrangements. The above steps will need to be repeated once FBC approval is complete and the project moves into the construction phase. Programme Project board July 2026 meeting agreed that the meetings would divide into separate meetings going forwards **Expected Evidence of Implementation:** The following actions will be implemented as part of the August meetings and will be ongoing; • The terms of reference of the Project Board and Team will be updated (and brought to the August meetings for adoption). • The meeting agendas and minutes will clearly state the meeting name, record attendance and discussion to

			demonstrate the separate matters that the two meetings cover. The project PEP will be reviewed and updated to reflect the current membership of the Project Team and Board as well as to record workstreams and the wider current status of the project. This updated PEP will be brought to the September Project Team and Board meetings.
		Medium Priority	**Officer:** Project Director
	Theme: Governance	Control Operation	**Target Implementation Date:** 28th August 2026

Objective 3: Financial	**Unsatisfactory**

Overview / Summary of Observations

At FBC stage, the project had an approved capital cost envelope of £17.1 million, which had been validated by the UHB's appointed Cost Advisers. Despite this, progression of the project has been paused pending the resolution of wider organisational financial pressures related to revenue affordability.

The Cost Advisers had been engaged during the development of the OBC and FBC through existing appointment arrangements. However, the appointment of Cost Advisers under a new contract was delayed following FBC submission. As a result, monthly cost reports were only produced by specific request during this period.

In the absence of regular cost reporting, there was limited evidence of a formal mechanism to monitor ongoing cost movement, risk exposure, or changes to key assumptions such as inflation, scope, or market conditions during the post-submission period. While project expenditure has been reported through existing financial reporting arrangements, the lack of structured financial input reduces assurance that emerging financial risks will be identified and managed in a timely manner.

	Key Findings: Financial	**Risk & Impact**	**Agreed Management Action**
4	Management should ensure that a proportionate and structured cost reporting regime is maintained established for the following stages current phase of the project. This should include regular monthly or exception-based financial reporting.	Emerging cost pressures or changes in underlying assumptions may not be identified in a timely manner.	**Agreed Action:** The FBC has not been approved as yet so the project has not proceeded to the construction phase where higher expenditure requires more detailed cost reporting. There is a relatively small residual approved OBC stage budget which will be expended, primarily on fees, in the Qtr 1 and 2 periods of 2026/27 for which a cost report will be requested from the now appointed Cost Advisor. This cost report will be shared with the Project Board and Project Director. **Expected Evidence of Implementation:** Monthly project cost reporting to both the project team and Project Board throughout the delivery of the project's lifecycle.
		Medium Priority	**Officer:** Project Director **Target Implementation Date:** Immediately
	Theme: Finance Management & Control	Control Operation	
5	The Board approved the FBC for the project, confirming strategic alignment and organisational commitment. However,	Delayed project progression.	**Agreed Action:** A letter escalating the issues has been issued by the Project Director to the SRO. The SRO is continuing to liaise with the

	a known increase in associated revenue costs was not resolved in a timely manner. As a consequence, the project has not secured funding within the current approval window. This creates a material risk to delivery timelines and overall affordability. Any delay is likely to expose the scheme to significant inflationary pressures. Furthermore, there is a risk that a future government may revise funding priorities, which could result in reduced or withdrawn support for the project. The UHB should look to resolve this as a matter of urgency and decide the course of action going forward with this project.	Cost Inflation	Directors of Finance and Corporate Governance in relation to the revenue approval assurance. A formal update on the change in position from the Board meeting on 29.01.26. is in draft form and under review prior to sharing with the Executive Team. This update provides the current status, notes that the key risks associated with the business case needs remain and provides the background along with an assessment and series of recommendations. The intent is that the assurance in relation to the revenue is provided and the update report and its recommendations finalised for the Executive Team no later than the meeting due to be held on 12.08.26.
			Expected Evidence of Implementation: • Copy of the update report and minutes of the Executive Team meeting. • Copy of the evidence or assurance associated with the revenue within the FBC scrutiny grid response after submission to WG.
		High Priority	**Officer:** SRO **Target Implementation Date:** End of August 2026
	Theme: Approvals	Control Operation	

Objective 4: Technical	**Reasonable**

Overview / Summary of Observations

The target cost for the scheme was subject to review, with evidence that it had been considered and formally approved by the board in accordance with the UHB's governance process.

Site surveys relevant to the development had been completed and had informed the preparation of the design. The outputs from these surveys were included within the tender documentation pack issued to potential supply chain partners, supporting a more informed basis for pricing.

While these arrangements are consistent with expected practise and provide a level of assurance over cost development and procurement readiness, the extent to which all site related risks have been fully mitigated will only become clear up through subsequent delivery phases.

Assurance for this objective has been deemed as reasonable noting that the preconstruction and enabling works were omitted from the original tender with this being addressed post FBC approval by the Board.

Objective 5: Advisers	Reasonable

Overview / Summary of Observations

The audit reviewed the procurement and appointment of project advisers to assess compliance with relevant procurement requirements and the appropriateness of contractual arrangements. The Full Business Case (FBC) set out a clear procurement strategy for both the Supply Chain Partner and professional advisers, including a defined rationale for the selected forms of contract.

The procurement of the Project Manager was undertaken in conjunction with NHS Wales Shared Services – Procurement Services, with responses evaluated against established criteria and subject to formal approval. This approach provides assurance that the procurement process was conducted in a fair, transparent, and compliant manner. It was also confirmed that advisers have been, and are being, appointed using standard NEC contracts, with roles and responsibilities clearly defined.

An initial delay was experienced in appointing the Project Manager due to the need to re-run the Invitation to Tender (ITT) process; however, this was subsequently completed within a reasonable timeframe. Further delays have been noted in the appointment of key professional advisers, including the Supervisor and Cost Advisor roles.

While these delays have the potential to impact project timelines, it is recognised that overall project slippage has provided a degree of flexibility for these appointments to be progressed without immediate adverse impact. On this basis, the level of assurance has been assessed as reasonable, reflecting that appropriate procurement processes are in place and being applied, albeit with some delays in implementation.

	Key Findings: Advisers	Risk & Impact	Agreed Management Action
6	The Supervisor and Cost Advisor are core roles in NEC managed capital projects, underpinning contract administration, cost control, and assurance. Management should in partnership with NWSSP Procurement engage to strengthen procurement planning and oversight for capital projects by establishing clear timelines, accountabilities and escalation routes for all key appointments post FBC approval.	Delays in appointing two key project roles create a risk for timely project mobilisation and effective governance.	**Agreed Action:** This commentary was included prior to issue of the report; The Procurement processes are now complete however the overall length of time they took is also very much a reflection of the lack of resource available within Procurement Services to progress these in a timely manner. The overall length of time it took to complete them (the procurement processes)was not in the Health Board's control. From our experience NWSSP Procurement Service do not have the adequate resource to support clear timelines even when agreed, with the ITT and other dates quoted to us being missed. The proposed action is that a timeline of procurement processes is maintained to support future procurements. This travelling file note could include activities such as; • Completion of any prior approval to issue of tender • Agree tender strategy • Collation period for tender documentation

			• Development of ITT • Publication of ITT and so forth with a set of dates agreed with NWSSP Procurement Services and a record of any changes to these dates or the steps involved. Both the Project Manager and Cost Advisor procurement processes here were also delayed by the need to issue a further clarification question which necessitated new technical and commercial returns because the submitted resource schedules did not provide assurance. The Supervisor procurement was repeated in its entirety because no responses were received initially. An additional proposed action is that the highlight report issued to the Project Team and Board not just reports these delays but prompts a review of the associated risk in the risk register to the delay. The implication of delays in appointments and agreement of alternative interim arrangements is to be escalated by the Project Director as appropriate.
			Expected Evidence of Implementation: • Draft timeline milestones file note for any later procurements in the project. • Reference to any later procurements in future highlight reports and meeting notes.
		Medium Priority	**Officer:** Project Director **Target Implementation Date:** On going
	Theme: Contractual	Control Operation	

Objective 6: Design	**Substantial**

Overview / Summary of Observations

A review of documented evidence at the FBC stage confirmed ongoing involvement of key clinical stakeholders in the design process. This included email correspondence confirming stakeholder satisfaction with clinical layouts (e.g. room configurations) and minutes from both the Project Board/Project Team meetings demonstrating regular updates, discussion of design elements, and stakeholder input into decision-making.

These arrangements provide assurance that relevant stakeholders were appropriately consulted and that requirements were incorporated into the design, reducing the risk that the completed facility would not meet clinical or operational needs.

While adequate design sign-off, approval processes, and change management arrangements were in place, the project ultimately stalled due to unresolved increases in forecast revenue costs between OBC approval and development of the FBC.

Objective 7: Planning	**Reasonable**

Overview / Summary of Observations

Planning permission for the proposed development was granted by Denbighshire County Council approximately six months prior to submission of the FBC to WG. Approval under the Sustainable Drainage Approval Body (SAB), in accordance with the Flood and Water Management Act 2010, had also been secured at that time.

At the time of audit, a single pre-commencement planning condition remained outstanding this being :

- A condition related to ecological Reasonable Avoidance and Mitigation Measures (RAMS). The Project Highlight Report dated 27 March 2026 confirmed that an ecologist had undertaken a further site survey, and an updated RAMS was awaited to support discharge of this condition.

Until this condition is formally discharged by the Local Planning Authority, there remains a risk that commencement of construction works may be delayed. In particular, no development may commence until a RAMS Method Statement for mammals and amphibians has been submitted to and approved in writing by the Local Planning Authority.

Project representatives confirmed that engagement with the Local Authority and relevant specialists was ongoing to facilitate discharge of the outstanding condition.

	Key Findings: Planning	Risk & Impact	Agreed Management Action
7	Whilst noting the current hiatus in respect of the progress of WG approval of the project, to ensure a timely ability to meet any positive outcome in this regard, management should ensure that: priority is given to progressing the discharge of the outstanding planning conditions, including timely submission of all required supporting information.	Delays in securing formal discharge of the outstanding pre-commencement conditions may delay the start of construction works, resulting in potential programme slippage and associated cost and delivery risks.	**Agreed Action:** The outstanding discharge of a condition is dependent on the submission of ecology RAMS to the Local Authority which has been delayed as the RAMS proposed by the incumbent ecologist were highly onerous with high levels of watching briefs and resource. The proposed action is that a new approach is agreed between the Project Manager and Design teams along with ecologist input prior to agreed RAMS being submitted. The specific focus relates to the removal of trees and shrubs alongside a culvert and given these are deciduous new RAMs could be produced in Oct-Nov 2026 for submission. This will not delay the start of construction works as this timeline is not a critical path activity and sits well within the overall FBC stage costing, approval and construction phase mobilisation stages. **Expected Evidence of Implementation:** • Copy of submitted ecology RAMS
		Medium Priority	**Officer:** Project manager for estates development

	Theme: Planning, Delivery & Deadline Management	Control Operation	**Target Implementation Date:** In line with FBC approval

Objective 8: Information	**Substantial**

Overview / Summary of Observations

This review assessed the adequacy and effectiveness off the information management systems supporting the capital project, with particular consideration given to whether the systems were reliable, effective, and fit for purpose. The review focused on the governance, storage, retention, and sharing arrangements in place for project information and documentation.

The project team maintained a structured SharePoint based file management system within Microsoft 365. Appropriate processes and controls had been implemented to support the secure storage, organisation, and management of project records through the project lifecycle. Access permissions and information sharing arrangements were found to be appropriately managed, supporting collaboration while maintaining control over sensitive information.

Overall, the review concluded that the existing information management arrangements provide a reliable and effective framework to support the delivery and governance of the capital project no significant weaknesses were identified that would impair the accessibility integrity or management of project information.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Betsi Cadwaladr University UHB. 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.

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