Bundle BCU Audit Committee 21 April 2026 v2.0

1 09:30 - PRELIMINARY MATTERS

2 AC26.26 Welcome and apologies (Pam Wenger & Dyfed Jones apologies)
Chair

3 AC26.27 Declarations of interest
Chair

4 AC26.28 Minutes of the previous meeting held on 17 February 2026 for approval
Chair
AC26.28 Minutes Audit Committee 17.2.25 v0.1 unconfirmed PUBLIC

5 AC26.29 Summary action log
Chair
AC26.29 Summary Action Log

6 GOVERNANCE, RISK AND ASSURANCE

7 09:40 - AC26.30 Update on Outstanding Audit Recommendations - Executive Director of Finance
Russ Caldicott Executive Director Finance
The Committee is asked to
Note the update
AC26.30 DoF Recommendations report Audit Committee April 2026

8 09:55 - AC26.31 Corporate Governance Report
Philippa Peake-Jones, Head of Corporate Governance in attendance
The Committee is asked to:
· NOTE the matters considered in Private at the 17 February 2026 meeting.
· NOTE the Committee forward workplan.
· NOTE the breaches to the Standing Orders relating to the late publication of papers
AC26.31a Corporate Governance report
AC26.31b App A Workplan Audit Committee

9 10:05 - AC26.31.1 Corporate Governance Improvement Plan
Philippa Peake-Jones Head of Corporate Governance in attendance
The Committee is asked to:
NOTE the progress against the Corporate Governance Improvement Plan.
AC26.31.1 Corporate Governance Improvement Plan

10 10:10 - AC26.32 Standards of Business Conduct
Philippa Peake-Jones, Head of Corporate Governance in attendance
The Committee is asked to:
SEEK ASSURANCE that ongoing monitoring and reporting will continue to strengthen compliance and transparency in relation to Declarations of Interest and Gifts and Hospitality.
AC26.32 Standards of Business Conduct

11 10:15 - AC26.33 Statutory Compliance Report
Glesni Driver, Head of Statutory Compliance and Inquiries in attendance
The Committee is asked to:
· NOTE the report
· APPROVE the closure of the Internal Audit recommendations, as per Section 4.2.2 of Annex A.

AC26.33a Compliance report 21.04.2026 v3.00
AC26.33b App 1 - IA Open Unsatisfactory v1.00
AC26.33c App 2 - IA Open Limited Assurance v1.00
AC26.33d App 3 - AW open v1.00
AC26.33e App 4 - IA for Exec closure v1.00
AC26.33f App 5 - IA for AC closure v1.00
AC26.33g App 6 - AW recs for Exec closure v1.00
AC26.33h App 7 All overdue policies v1.00

12 10:25 - AC26.34 Corporate Governance Code
Philippa Peake-Jones, Head of Corporate Governance in attendance
The Committee is asked to:
• NOTE the compliance with the corporate governance code;
• SUPPORT the assessment of compliance against the corporate governance code; and
• AGREE to the assessment being reflected in the accountability report.
AC26.34 Code of Corporate Governance

13 FINANCE

14 10:30 - AC26.35 Update on Draft Annual Accounts 2025/26 (verbal)
Russ Caldicott, Executive Director Finance
The Committee is asked to
NOTE the verbal update

15 10:35 - Break

16 10:45 - INTERNAL AUDIT

17 AC26.36 Internal Audit Progress Report / Internal Audit Plan, Mandate and Charter 2026/27
Dave Harries, Head of Internal Audit
On Call arrangements - Tehmeena Ajmal, Chief Operating Officer in attendance
NICE Guidelines compliance - Clara Day, Executive Medical Director in attendance
The Committee is asked to:
· Note the findings within the progress report and associated audit reports.
· Approve the internal audit plan, mandate and charter for 2026/27
AC26.36a IA progress report April 2026
AC26.36b BCUHB Audit Committee progress report April 2026
AC26.36c BCUHB Final Internal Audit Plan 2026-27

19 11:15 - EXTERNAL AUDIT

20 AC26.37 Audit Wales : Update to BCUHB Audit Committee
AC26.37 Audit Wales BCUHB Audit Committee Update (April 2026)

21 AC26.38 Audit Wales : BCUHB Structured Assessment 2025 report
AC26.38 Audit Wales BCUHB Structured Assessment 2025 Final Report

22 AC26.39 Audit Wales : BCUHB Draft Annual Audit Summary report 2025-26
AC26.39 Audit Wales BCUHB Annual Audit Summary 2025

23 AC26.40 Audit Wales : Draft Annual Audit Plan 2026-27
AC26.40 Audit Wales BCUHB Audit Plan 2026

24 11:45 - COUNTER FRAUD

25 AC26.41 Local Counter Fraud Service progress report and Workplan for 2026/27 (for approval)
Danielle Timmins, Head of Local Counter Fraud
The Committee is asked to:
NOTE the contents of the report
APPROVE the Counter Fraud Workplan for 2026-27.

AC26.41a PUBLIC - Q4 25-26 Counter Fraud Report
AC26.41b PUBLIC CFraud report- Appendix A - AC Dashboard Q4 25-26
AC26.41c PUBLIC CFraud report Appendix B - Proposed Counter Fraud Workplan 2026-2027

26 11:55 - CLOSING BUSINESS

27 AC26.42 Agree items for referral to Board / Other Committees
Chair

28 AC26.43 Review of meeting effectiveness
Chair

29 AC26.44 Date of the next meeting : 23.6.26

30 12:00 - Resolution to exclude the Press and Public
"representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed minutes of the Audit Committee
held in on 17 February 2026
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Paul Lambert	Independent Member (Chair of Audit Committee)
Urtha Felda	Independent Member (Vice Chair of Audit Committee)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member (via Teams)
In Attendance	
Russell Caldicott	Executive Director of Finance
Glesni Driver	Head of Statutory Compliance & Inquiries
Dyfed Edwards	Health Board Chair (part meeting)
Jody Evans	Assistant Head of Risk Management
Debbie Eyitayo	Executive Director People Services and Organisational Development (OD) (via Teams)
Dave Harries	Head of Internal Audit, NWSSP
Fflur Jones	Performance Audit Lead, Audit Wales
Nicola Jones	Deputy Head of Internal Audit, NWSSP
Michelle Phoenix	Performance Audit Lead, Audit Wales (part meeting)
Danielle Timmins	Head of Local Counter Fraud
Pam Wenger	Director Corporate Governance
Angela Wood	Executive Director of Nursing & Midwifery (part meeting)
Observing	
Cathy McHarrie	Local Counter Fraud Specialist
Lina Darras	Financial Management Graduate Trainee (part meeting)
Committee Support	
Philippa Peake Jones	Head of Corporate Governance
Diane Davies	Corporate Governance Manager

PRELIMINARY MATTERS

AC26.1 – Welcome and apologies for absence

The Chair welcomed all attendees to the meeting. No apologies were received.

AC26.2 – Declarations of Interest

No declarations of interest were received.

AC26.3 – Unconfirmed Minutes of the meeting held on 16 December 2025

It was **agreed** that the minutes of the meeting held on 16 December 2025 were a true and accurate record.

AC26.4 – Matters Arising and Summary Action Log

The Committee received the action log and noted progress across multiple items. A number of actions related to operational governance, internal audit recommendations, and contracted patient services were discussed at length, and the actions updated accordingly. Members emphasised the importance of realism in timescales, clear accountability, and consistency across committees.

It was noted that the long-standing action in relation to the Centre for Mental Health Society was on the agenda in the private meeting; however, it would remain open until the report was considered in public.

ACTIONS:
AC26.4.1 Executive Director of Finance to arrange to advise the Ombudsman of delay to implementation of the Commissioning Framework.
AC26.4.2 Director of Corporate Governance to address breach issues with the Committee Advisory Group.
AC24/151.1 To remain open as Centre for Mental Health and Society draft internal audit report discussed in private session.

Actions proposed for closure were **agreed**.

GOVERNANCE

AC26.5 – Update on Outstanding Audit Recommendations
Angela Wood, Executive Director of Nursing & Midwifery presented the item.

A detailed review of outstanding internal audit recommendations was provided, including:

- Progress on limited assurance areas such as falls management, complaints handling, manual handling, and patient experience.
- Improvements had been made since previous Health and Safety Executive (HSE) notices of contravention.
- Ongoing recruitment challenges in specialist training roles.
- Assurance that new governance processes, dashboards, and oversight mechanisms were embedding improvements.

Committee discussion:
Members:

- Queried the longevity of recommendations and the cultural factors contributing to historical delays.
- Recognised significant progress in training, compliance, and assurance processes.
- Stressed the importance of embedding learning, ensuring evidence quality, and sustaining improvements long-term.
- Recognised that complaint handling had improved to being the best performing in Wales and that delivery of the new national complaints framework would be monitored via the Quality, Safety and Experience Committee from 1 April.

The Committee resolved to

NOTE the update and **SUPPORT** continued oversight measures.

AC26.6 – Statutory Compliance Report
Glesni Driver, Head of Statutory Compliance & Inquiries presented the item.

The report highlighted:

- 50 internal audit recommendations presented for closure.
- 14 Audit Wales recommendations presented for closure.
- Persistent issues linked to delayed management responses, poor evidence submission, and operational pressures.
- Significant statutory compliance risks—including water safety governance concerns—requiring strengthened attendance, accountability, and cross-team coordination.

Committee discussion:
Members raised concerns regarding:

- Inadequate attendance at key statutory compliance meetings.
- Cultural issues within departments where repeated failures occur.
- Reputational risks arising from governance failures and overdue actions.

The Director of Corporate Governance stated that governance education needed to be promoted within the organisation to strengthen operational grip on processes and ensure appropriate ownership, highlighting the journey that she and her team were on to make these improvements now that governance on a corporate level had embedded effective structures and processes e.g. through delivering governance masterclasses open to all BCU employees. In response to the Health Board Chair's concerns regarding the lack of responses at Executive level she gave assurance that discussion with Executive Directors would be held to ensure appropriate facilitation was in place to provide timely supporting evidence.

ACTION:
AC26.6.1: Share with members updates for Ysbyty Gwynedd Emergency Department (ED) actions and Ombudsman deadlines.

The Committee resolved to
APPROVE the closure of Internal Audit and Audit Wales recommendations as set out in Annex A.

AC26.7 – Corporate Governance Report
Pam Wenger, Director of Corporate Governance presented the item.

The report included:

- Summary of business considered in private session for reporting in public.
- Forward workplan updates.
- Progress on Learning From Events Report (LFER) and strengthening evidence of embedded learning.

Committee discussion:
Members supported:

- Improvements to governance capability across the organisation.
- Need for improved evidence of sustained learning from historic incidents.
- The role of Internal Audit in future assurance of embedded learning.

The Committee resolved to
NOTE the report.

AC26.8 – Director's Accountability Statement 2026/27
Pam Wenger, Director of Corporate Governance presented the item.

The Committee received the proposed Directors' Accountability process for 2026/27, aligning accountability, assurance, and annual performance frameworks. The Director of Corporate Governance emphasised the importance of establishing the arrangements in order to strengthen accountability across the organisation and this process would align to the Performance Management Framework and support the Chief Executive Officer as part of her responsibilities in relation to the systems of internal control. Members were invited to submit any further comments following the meeting.

Committee Discussion:
Members welcomed the clarity and structure the new process provided and emphasised:

- Importance of directors understanding their statutory and governance responsibilities.
- Need to cascade accountability deeper into operational levels.

The Committee resolved to
SUPPORT implementation of the Accountability Statements for 2026/27.

AC26.9 – Annual Report 2025/26 Arrangements
Pam Wenger, Director of Corporate Governance presented the item.

A timeline for preparing the Annual Report and Accounts for 2025/26 was shared, consistent with Welsh Government Manual for Accounts requirements. Dependencies between Audit Wales, Finance, and governance teams were noted. The Committee Chair emphasised the importance of the avoidance of slippage in the timelines outlined.

The Committee resolved to
NOTE the arrangements.

AC26.10 – Corporate Risk Register (CRR)
Pam Wenger, Director of Corporate Governance presented the item.

The Committee received an update on organisational progress around risk management. Significant improvements had been made over the past year in risk assessment processes and governance mechanics. The key focus for the coming months was shifting from process improvement to active risk reduction.

Progress was reported in respect of

- The organisation had strengthened the processes and mechanics of risk assessment, reporting and committee oversight.
- Internal Audit's draft report on risk was awaited.
- Current risk papers highlighted that ten risks remain outside the Board approved risk appetite.
- A paper had been presented to the Executive Committee outlining plans to conduct deep dives on each individual risk over the next six months. The Committee commended this approach.
- These deep dives would identify specific actions required to reduce risk levels, with clear accountability.
- Priority focus: identifying actions that would move risks into the risk appetite range, even if not fully reaching the long term target risk score.
- The Quality Management System would be the subject of the next Board Development session.

ACTION
AC26.10.1 Staff stress related sickness should also capture and report on 'work related' sickness within future reporting.

The Committee resolved to

- **ENDORSE** the Corporate Risk Register (January 2026) as the current consolidated position.
- **NOTE** that ten risks remain above appetite
- **NOTE** the incorporation of **BAF2401** actions within **CRR2508** and monitoring arrangements.

AC26.11 Governance and Accountability Framework
Pam Wenger, Director of Corporate Governance presented the item.

The Committee received an update on the annual review of the Standing Orders (SOs) and Standing Financial Instructions (SFIs), as required under governance best practice.

Key Points

- Annual review of SOs and SFIs had been completed, in line with governance requirements.
- Updates were largely technical and clarificatory, not substantive.
- No changes had been made to financial delegation limits.
- Revisions included:

- Updated job titles and terminology.
- Clearer descriptions of approval pathways.
- Corrections to missing or ambiguous sections.
- Clarified processes for income flowing into the organisation.
- General formatting improvements for consistency.

- Work had been completed jointly by Governance and Finance teams.
- SOs and SFIs were intended to be endorsed annually as good practice.

Committee discussion:

- Confirmation was provided that Committee membership could include external (non-LHB) members if specialist expertise is required.
- A request was made to improve document accessibility, including large print options.

The Committee resolved to
APPROVE the proposed changes to the Scheme of Reservation and Delegation (SoRD) for onward approval at the Board in March 2026.

FINANCE
AC26.12 – Finance Conformance Report
Russell Caldicott, Executive Director of Finance presented the item.

The report covered:

- Improvements in No PO No Pay compliance, though terminology refinement is needed.
- Single tender waivers reducing year-on-year.
- £8m in outstanding invoices, largely within 30-day norms.
- Concerns regarding overpayments to staff due to untimely termination forms.
- Public Sector Payment Policy compliance at 97%.

Committee discussion:
Members

- sought assurance that BCU ensured robust processes were in place to avoid the potential for salary overpayments and associated reputational risk.
- raised concern with the volume of invoices awaiting payment which exceeded the 30 day deadline.

The Committee resolved to
NOTE the report and **APPROVE** losses and special payments.

AC26.13 – Counter Fraud Report
Danielle Timmins, Head of Counter Fraud presented the item.

Key points:

- Increased reporting of suspected fraud, particularly related to working while sick and phishing-based mandate fraud.
- Resource limitations due to staff sickness within the Counter fraud team.
- Significant cases involving prescription theft, restrictions on clinical practice, and fraud identified within a GP practice.

- Preventative work ongoing across GP practices and pharmacy claims.

Committee discussion:
Members emphasised:

- The need to address cultural issues where fraud is normalised.
- Importance of documenting mandatory fraud education.
- Need for HR engagement where repeated or systemic issues were identified.

The Committee resolved to
NOTE the report and **APPROVE** case closures.

INTERNAL AUDIT

AC26.14 – Internal Audit Progress Report
Dave Harries, Head of Internal Audit presented the item.

Internal Audit reported:

- Three reports issued in the period: one Reasonable, two Limited Assurance.
- Significant deterioration in timely management responses.
- Concerns regarding statutory compliance (e.g. water safety governance).
- Forward indicators suggest a challenging year-end opinion.

Committee discussion:
Members highlighted:

- Concern with gaps in primary and community reporting at Board level, albeit was acknowledged that BCU operated a Primary Care Board and the Planning, Population Health and Partnerships Committee received updates in these areas.
- Concern with gaps in Estates governance and compliance however, the Director of Corporate Governance provided assurance that the Executive Committee was in the process of addressing this area through the establishment of a Regulatory Group.

The Committee resolved to
NOTE WITH CONCERN the deterioration in assurance levels and emphasised the need for executive focus.

AC26.15 External Audit Progress report
Fflur Jones, Auditor - Audit Wales presented the item.

Audit Wales reported:

- Planning work underway for the 2025/26 financial audit.
- Structured Assessment near completion.
- Ongoing performance audit work: digital services, estates, strategic financial systems.

The Committee resolved to
NOTE the update.

CLOSING BUSINESS

AC26.16 – Items for referral to the Board / other Committees

The Committee **AGREED** to refer:

- Risks linked to statutory compliance governance.
- Declining Internal Audit assurance and management response performance.
- Progress and risks relating to outstanding audit recommendations.

AC26.17 – Review of meeting effectiveness

Members agreed the agenda enabled meaningful discussion on key governance risks and that the agenda had been well planned and effectively chaired.
Opportunities were noted to:

- Avoid agenda overload.
- Maintain structured forward planning.
- Ensure adequate time for substantial items.

AC26.18 – Date of next meeting

21 April 2026

Resolution to exclude the Press and Public

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

Audit Committee Action Log (Public)

Updated 14.4.26

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
			REMAIN OPEN			
1	**QS26.38.2**	0	**Transferred action from QSEC:** Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	Executive Director Nursing and Midwifery	June 2026	**Remain Open** Entered on workplan
2	**AC26.4.2**	17.2.26	**Matters arising** Address realistic timing of when the Committee actions are due via the Chairs Advisory Group	Director of Corporate Governance		**Remain open** 09.04.26 This will be added to the next agenda for CAG
3	**AC26.10.1**	17.2.26	**Corporate Risk Register (CRR)** Staff stress related sickness should also capture and report on 'work related' sickness within future reporting.	Director of Corporate Governance / Executive Director People Services & OD	June 2026	**Remain open** 9.3.26 Jody Evans informs this is being written into the CRR update by the responsible lead.
4	**AC25.167**	17.12.25	**Internal Audit Progress Report** The Head of Internal Audit to follow up the Learning – Regulatory Reporting (BCU-2526-11) report with the Director of Corporate Governance and re-present to the Committee at a future date.	Dave Harries	May 26	**17.2.26 Remain open** **27.1.26** The five agreed management actions have two key milestones for implementation, 31 March 2026 and 31 March 2027 respectively. The key governance

						action is set for 31 March 2027 implementation; any review prior to this would not capture the required governance arrangements being in place. Subject to Audit Committee approval, a review will be undertaken in Quarter 1 of the 2027/28 internal audit plan.
5	**AC25/136.1**	21.10.25	**Statutory Compliance Report** A copy of the documentation in relation to the Major Project Governance and Contractor Management Review to be shared at the next meeting in December 2025.	~~Pam Wenger~~ Russell Caldicott	Feb 26 April 2026	**Remain Open** **09.4.26** This is scheduled to be on the agenda **17.2.26** Concern was raised on the delay to presentation of the report however assurance was provided that it would be presented to the next meeting**.** **10.2.26** The Report is in the process of being finalised and will be brought through to the next meeting. **1.12.25** Chief Executive confirmed at the Board meeting on 27.11.25 that the Commissioning Assurance Framework was in draft.
6	**AC25/136.2**	21.10.25	**Statutory Compliance Report** Director of Corporate Governance to follow up the progress in relation to the implementation of a Commissioning Assurance	Russell Caldicott	Feb 26 April 2026	**Remain Open** **09.04.26** This is scheduled to go to be considered at PFIGC and then to Board. **10.3.26** This is scheduled to be

			Framework outside of the meeting and report back to the Committee.			dealt with by the Performance, Finance and Information Governance Committee (PFIGC. **17.2.26** Concern was raised on the delay to presentation of the report however assurance was provided that it would be presented to the next meeting**.** **10.2.26** This now falls under the remit of the Executive Director of Finance. The document is in draft and being worked through by the Executive Lead. **1.12.25** Chief Executive confirmed at the Board meeting on 27.11.2025 that the Commissioning Assurance Framework was in draft.
7	**AC24/151.1**	05.11.24	**Centre for Mental Health and Society (CfMHaS)** (Title changed from Response to Freedom of Information Request) A full evaluation report to be presented at the next Audit Committee.	Pam Wenger Russell Caldicott	March 25 May 25 Revised timescale June 26	**Remain Open** **09.04.26** This item will be received at the next Audit Committee. An explanation has/will be shared outside of the meeting. **10.3.26** Public session agenda item 21.4.26 09.02.26 On the private agenda for 17.02.26. 27.01.26 Draft internal audit report has been issued to the Health

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

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

			risk is logged and bring the item back to the Committee.			submission when resource available to progress. **17.2.26** Noted due to be presented at the next meeting **11.09.25** The PFIG Committee received an update on Information Governance and Records Management at their meeting on 26.08.25 - please see link below to the paper and note item PF25.74 Information Governance: PFIG Agenda Bundle 26.08.25 This requires further discussion with the DDaT Team. **29.07.25** A session on records management to take place with the Executive Committee and this will be included on the agenda for a more substantive item at a future meeting. **19.03.25** Dylan Roberts to discuss with Carol Shillabeer and agree how the corporate records management function will be resourced. A paper will be presented to the Executive Committee and come back to a future meeting of the Audit Committee.
ACTIONS PROPOSED FOR CLOSURE						
1	**AC26.6.1**	17.2.26	**Statutory Compliance Report**	Director of	20.3.26	**Propose for closure**

			Share with members updates for Ysbyty Gwynedd Emergency Department (ED) actions and Ombudsman deadlines.	Corporate Governance		**9.3.26** Circulated information, prepared by Glesni Driver, to members via email
2	**AC26.4.1**	17.2.26	**Matters arising** Arrange to advise the Ombudsman of delay to implementation of the Commissioning Framework.	Executive Director of Finance	20.3.26	**Suggest closure** The Ombudsman has been made aware of the delay to implementation.
Closed Actions (as agreed at meeting on 17.2.26)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**AC25/109.1**	19.08.25	**Matters Arising and Action Log** Director of Corporate Governance to discuss the Contracted Patient Services Review with the Chief Executive, circulate a briefing outside of the meeting and further consideration of progress to be reported at the next Committee meeting.	Russell Caldicott	Dec 25	**17.2.26 Agreed for closure** (this action is superseded with 136.2) **10.2.26** This item is the same as 136.2 so suggest this is closed to avoid duplication. Meeting has taken place with the Director of Finance and Director of Nursing. **6.1.26** Meeting to be arranged with Lead Executives before next meeting This now falls under the remit of the Executive Director of Finance to update in the meeting. **4.12.25** Progress update pending **11.09.25** Director of Corporate Governance to discuss with the Chief Executive and report back to the Committee.
2	**AC25.161**	16.12.25	**Statutory Compliance Report**	Glesni Driver	February 26	**17.2.26 Agreed for closure**

			Head of Statutory Compliance and Inquiries to provide greater detail on progress of all open Ministerial Directives in future reports.			This has been noted. The information presented to the December Audit Committee reflected the agreement in place from the Audit Committee meeting on 8 May 2025 where there would be a six-monthly report to Audit Committee on newly-published WHCs and MDs
3	**AC25.165**	16.12.25	**Finance Conformance Report** Whilst it was acknowledged that there had been a reduction in outstanding learning reports, the Deputy Director of Legal Services would be contacted to provide greater assurance that patient experience remained a focus to learn from and processes were in place to avoid the application of penalties.	Matt Joyes	Matt to confirm	**17.2.26 Agreed for closure** There is an updated paper included as an Appendix to the Corporate Governance Report.

Audit Committee

Executive Director of Finance
Update Presentation on Open Audit Recommendations

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

21st April 2026

Internal Audit - Limited and Unsatisfactory Audit Recommendations

Report Title	Year	Number of report recommendations	Number of limited / unsatisfactory assurance recommendations	Number of recommendations implemented / complete	Total number of report recommendations open
Follow-up Audit: Contracted Patient Services: Quality and Safety Arrangements	2025	5	5	0	5
Performance Management Framework and Reporting	2025	3	3	0	3
Orthopaedic Surgical Hub Llandudno Hospital 2025	2025	13	13	9	4

Internal Audit - Limited and Unsatisfactory Audit Recommendations

Report Title	Year	Number of report recommendations	Number of limited / unsatisfactory assurance recommendations	Number of recommendations implemented / complete	Total number of report recommendations open
Contract management and procurement review – Corporate Directors	2025	5	3	2	3
Value and Sustainability – Delivering Quality Improvements	2025	3	3	0	3

Follow-up Audit: Contracted Patient Services: Quality and Safety Arrangements

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Process Management The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management, both where the Health Board is commissioner and provider.	The CAF has been presented in draft form to PFIG committee on 24/02/2026.	CAF to go to Board meeting
Contractual Obligations The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings.	The CAF has been presented in draft form to PFIG committee on 24/02/2026	CAF to go to Board meeting
Quality Measures 1) Quality schedules will be included in contracts that reflect national requirements. 2) The Health Board will, as part of the CAF mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing monitoring via ad hoc meetings, contract meetings or any other forum required.	1) Discussions are ongoing with commissioning and quality teams to update quality measures and will form part of the CAF. 2) The CAF has been presented in draft form to PFIG committee on 24/02/2026	CAF to go to Board meeting
Board Assurance. The Health Board will establish a six-monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF.	Delayed due to retirement of the Director of Performance and Commissioning	To be presented to future meetings, commencing in May 2026.

Performance Management Framework and Reporting

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Governance The Integrated Performance Framework (IPF) to be fully implemented during quarter 2 of 2025/26. This will entail monthly meetings with the larger management structures delivering patient care. The reporting hierarchy will ensure “ward to board” assurance reporting.	The IPF has been revised and will be replaced by the Integrated Performance Improvement & Accountability Framework 2026-2029 (IPIAF). At the time of reporting, this Framework is in Draft form and will be finalised and submitted to the HB for approval in May 2026. In the meantime, supporting tools, mechanisms, policies and governance processes are being developed and will be ready for deployment as soon as the Framework is endorsed.	Draft version has been shared with board members and executive team for comment. Final progress is being made before presentation for sign off at Health Board Meeting.
Performance Local performance indicators and escalations are created where a service’s performance is showing early signs of distress or consistently failing a target. Whilst outside of the NHS Wales performance framework, it is essential to identify areas that need further scrutiny and assurance as the NHS Wales performance framework cannot cover all delivery of the NHS. The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any local metrics.	Within the supporting elements of the new Integrated Performance Improvement and Accountability Framework (IPIAF) there is a detailed 'escalation and de-escalation' policy. This policy will be used to determine the levels of escalation and therefore the appropriate governance routes of all metrics, national or local. The policy engenders rational and objective escalation/ de-escalation of metrics through an unbiased algorithmic process.	This information will be incorporated into the IPF, work continues to progress with the performance team taking lead.
Performance Accountability The Health Board is in the process of setting up monthly meetings with IHCs and pan BCU patient facing services. Initial meetings have been held in quarter 1 (2025/26) with monthly meetings to be diarised during quarter 2 to run monthly from September onwards.	The new IPIAF mentioned above for 2026-2029 features a suite of supporting elements, of which regular Integrated Performance Improvement and Accountability Reviews are a critical component. These Reviews are to be held at various levels of the organisational hierarchy starting with high level executive reviews, and as the implementation of the IPIAF progresses, will work down through the organisational hierarchy eventually being incorporated within every employee's Personal Appraisal Development Reviews (PADRs). The supporting documentation for the IPIAF includes Terms of Reference and will include a timetable of all the IPIA Reviews for the fiscal year.	Executive-led Directorate Level Integrated Performance Reviews, for both Clinical facing and all corporate support services are undertaken on a consistent basis in line with the governance Super/Sub structure. Evidence of outcomes from these reviews are retained enabling review whether the set actions have been implemented and made a difference.

Orthopaedic Surgical Hub Llandudno Hospital 2025

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Procurement/Contract Strategy Each specific project within the annual Capital Programme shall be subject to a documented delivery strategy including the project specifics, phasing/decant plan, design strategy, procurement strategy, risk management strategy and shall be used as part of the contract selection criteria. The strategy for each project shall be presented to the Director of Environment and Estates for agreement prior to inclusion in the business case. This shall be part of the business case (Commercial Case) and shall document the contract adopted and the benefits and risks. The approach undertaken with regards to Llandudno will not be progressed for future developments, with contracts awarded based on financial ceilings. *LIOH: Contract executed so limited opportunity to change other than specific terms and such is unlikely to be accepted by the contractor.*	Due to the stage of the project, there is little opportunity to amend LIOH in this regard now other than to actively use and enforce the contract terms. Whilst there remains a narrative that the JCT contractors design shall never be used by BCU again, this should not be the case. The form of contract should reflect the specific requirements of the project and SFI's and be included in the procurement strategy at the outset.	The Health Board is unable to amend the design or select an alternative construction partner for this project at this time. However, an Internal Audit report on lessons learnt has been commissioned through the office of the Chief Executive and Director of Corporate Governance. The outputs and recommendations from this review will be embedded within future construction commissions and these recommendations therefore closed at this point.
Design delays The design strategy included in Action 1 above will be used to assess the core packages to be employer or contractor designed and include: 1. Who undertake what design packages. 2. The design stages. 3. Design transfer/novation arrangements. 4. Design warranty or professional indemnity arrangements. 5. Roles and responsibilities under the contract and for the retained team. 6. Coordination and technical submission arrangements and design variance obligations/restrictions. The criteria may vary according to the specific project. Each project shall, at the earliest opportunity, include an integrated programme for all stages to post-occupation evaluation to the design strategy. The design development, programme and risks shall be reviewed monthly and reported with escalation and mitigation. *LIOH: Continue to report and review monthly with escalations and mitigations.*	For LIOH, mitigation measures are in place. The wider implications can be picked up in the Capital Process manual. Agreement to a working design supported as compliant for environment for treatment of these patients, supported through NWSSP colleagues and Welsh Government.	As above

Orthopaedic Surgical Hub Llandudno Hospital 2025 (continued)

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Inspection restrictions BCUHB staff responsible for site visits shall be required to attain the appropriate CSCS accreditation commensurate with their role. This shall be deemed an essential qualification to the satisfactory execution of their duties. *LIOH: Staff to be requested to obtain CSCS accreditation if their role requires it..*	At present, the BCUHB staff have not completed the CSCS examination process. In the meantime, mitigation arrangements are agreed with contractors to ensure free and unencumbered access to undertake site visits and inspections.	As above

Contract management and procurement review – Corporate Directors

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Accountability Agreements Ensure all Tier 1–2 officers sign Accountability Agreements for 2025/26. Escalate non-compliance to Audit Committee with reasons for refusal	Out of the Tier 1 and Tier 2 officers, one tier officer has not responded and one officer has not signed but there is valid reason due to long term absence. 413 out of 433 accountability agreements were signed across the Health Board. Out of the 20 not signed, 8 had a valid reason for not signing (for example, due to long term absence from work, etc.) and 12 provided no response.	New Accountability Agreements are to be issued for 2026/27. Any agreements not signed will be reviewed and discussed with the individual to establish reasons for non-agreement.
Direct Call Off (DCO) framework use Procurement training to ensure the reduction in Direct Call Off by engaging NWSSP Procurement Services at planning stage. Monitor and report DCO usage quarterly (via procurement report)	Procurement training sessions are ongoing to ensure all Directors and budget holders have attended.	Procurement training sessions for Directors and Budget Holders are to continue in 2026/27 with any new budget holders included. Additional Budget Holder training to be developed and issued, including the new All Wales training module developed by the NHS Wales Finance Academy.
Compliance with the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) Deliver update sessions on revised SFIs and SoRD to all Executive and Corporate Directors. Notify NWSSP Procurement Services of all delegated officers authorised to sign contracts. Ensure all contracts are signed by authorised officers before commencement.	Procurement training sessions are ongoing to ensure all Directors and budget holders have attended.	Executive and Corporate Directors receive an update session on the requirements and expectations laid out in the Standing Financial Instructions and cascade this to their respective management teams. Tier 1 to Tier 5 delegated and authorised to sign contracts per the Scheme of Reservation and Delegation (SoRD) notified to NWSSP Procurement Services. Health Board Contracting Team ensure contracts are signed at the outset and by the officers delegated in the SoRD.

Value and Sustainability – Delivering Quality Improvements

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Value and Sustainability 1.0 Combine Clinical Variation & Value-Based Health Care into a merged workstream which will act as the primary driver for quality-led clinical improvement initiatives within the V&S framework. This newly formed workstream will be operational in Q4 (with priority areas of focus agreed by end Feb-26).	1.0 Clinical Variation and Value-Based Heath Care workstreams combined, inaugural meeting to be held. Priority areas confirmed via national V&S Board. .	1.0 Workstreams now combined and inaugural meeting scheduled for 16 April and to be chaired by the Executive Medical Director with extensive clinical input.
1.1 A comprehensive 'Value' benefits framework is already in development based on the HFMA value definition: Outcomes + Experience / Cost (developed in conjunction with BCU's Benefits Lead). This will provide a more holistic (quality) view of programme delivery, over and above savings. The final version will be presented for ratification at Programme Board Feb-26. Any future initiatives will be prioritised against this wider framework.	1.1 Benefits framework developed, to be submitted at re-scheduled Programme Board.	1.1 Benefits framework covering the wider determinants of value developed and to be reviewed by Programme Board in April-26. This will support the development of the schemes within workstreams 5&6 which are focussing more on efficiency, productivity, outcomes, experience and environmental value metrics
1.2 Work has commenced with the PMO to refine and utilise the Portal as the vehicle to capture and report benefits realisation for 'non-transactional' value schemes that deliver against multiple metrics of value. This will sit alongside the existing national monitoring return, which focuses exclusively on cost savings. This will be completed by end of March-26 and be operational for delivery against our agreed programme of work for 26-27	1.2 Discussions commenced with PMO team, however timeline for delivery will require re-scheduling	1.2 Work continues with senior PMO team to utilise Portal for capturing programme benefits. All funded projects for 26/27 to be uploaded and monitored via the Portal.
1.3 Programme reporting (particularly highlight reports and reports into IPEDG and PFIG) will cover the wider set of value metrics included in the benefits framework. This will be in place for end of March-26 and will provide greater assurance around the quality outcomes of the V&S programme for 26-27.	1.3 Highlight report amended	1.3 Highlight report amended and wider metrics to be reported once wider portfolio of projects agreed and operational (May-26)

Value and Sustainability – Delivering Quality Improvements

Recommendation / Agreed Management Action	Progress	Plan and timeline for delivery
Saving Submission Documents 2.1 Reinstate the submission deadline to ensure that all SSDs are submitted with sufficient time to fully evaluate the supporting documentation. 2.2 Review of the narrative in the 'BCU Guidance for Savings' to allow planned savings information to be contained within a specialist system (e.g., in this case the meds management system), with the output from the system being sufficient to demonstrate the estimate provided for the saving value is reasonable. (Avoiding duplication of systems and ensuring one source of information).	The guidance is in the process of finalisation.	The guidance has been updated, adopted and circulated. This reaffirms the deadlines, and now incorporates the ability to keep transactional detail regarding savings in a specialist system where this might avoid unnecessary duplication. Evidence has been supplied to support closure within the latest updates due April 22nd 2026.
Actual Savings Reconciliation 3.1 The guidance on how to adjust future savings values to correct estimates, where actual information is not available at the point of submission is not clear. Advice will be taken from WG, as potentially limiting over estimates to one scheme may result in over reporting for some months. When guidance is received, we will strengthen the internal guidance to incorporate the WG views and advice. 3.2 WG have confirmed the Mental Health and Learning Disabilities scheme has been recorded correctly and in accordance with their requirements. However, it is recognised that neither the WG or BCU internal guidance specifically document the process, and the internal guidance will be strengthened to ensure this scenario is covered.	Advice has been received from WG and the guidance is in the process of finalisation.	The guidance has been updated, adopted and circulated to incorporate the advice from WG.- Evidence has been supplied to support closure within the latest updates due April 22nd 2026.

Corporate Risks / Board Assurance Risks

RISK TITLE	OPEN DATE	TARGET DATE	CURRENT RISK SCORE	TARGET RISK SCORE	KEY ACTIONS TO REDUCE THIS RISK SCORE	BARRIERS TO IMPLEMENTATION / DELIVERY	RISK APPETITE
BAF24-03 Not Achieving Long Term Financial Sustainability and CRR25-06 Value Delivery and Financial Sustainability	21/08/2025	31/03/2026	20	12	a. Prior year and current year financial performance material deterioration and therefore additional actions are required to control the run rate and reduce the deficit to a balanced position. These have been previously endorsed for implementation through the Integrated Performance – Executive Delivery Group. b. Health Board delegation to Executive to produce a recovery plan, Health Board working group formed to provide Board oversight with PFIG Committee to mitigate against the year-to-date deficit and risk to attainment of target break even whilst assessing impact on patient safety and quality. c. Performance is reported and scrutinised through the IP-EDG monthly meetings where officers are held to account for delivery. A 1.5% cost benefit and savings ask delivery is required as a minimum	The key risks centre upon cost overruns from out of area referrals for mental health patients and patient flow out of the Hospital resulting in cost exposure from requiring additional capacity areas to remain open and additional costs within Emergency Care front of house, combined with an inability to deliver savings plans, reduced investment in transformation.	Above tolerance

Corporate Risks / Board Assurance Risks

RISK TITLE	OPEN DATE	TARGET DATE	CURRENT RISK SCORE	TARGET RISK SCORE	KEY ACTIONS TO REDUCE THIS RISK SCORE	BARRIERS TO IMPLEMENTATION / DELIVERY	RISK APPETITE
					d. Gaps in delivery of savings targets mandated to be met on a recurrent basis e. Escalation meetings where improvements are not realised will continue to be held with leadership teams by the Chief Executive. In these forums, support is offered to improve performance and trajectories supported for improvement. f. Prioritisation exercise involving £42m transformation funding received on a conditionally recurrently basis to the end of 2025/26 completed for clinical schemes, with requirement to disinvest / identify alternative funding streams prior to new developments being funded. g. Consideration of additional strengthening of enhanced establishment controls and vacancy freeze for non-patient facing roles and continued reduction in variable staffing costs		

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Audit Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	21 April 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary
Members are asked to: • **NOTE** the summary of business considered in private session to be reported in public • **NOTE** the forward workplan • **NOTE** the breaches to the Standing Orders relating to the late publication of papers

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
IHC	Integrated Healthcare Community

CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA**
SITUATION

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR**
BACKGROUND

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

4 **MATERION PENODOL I'W HYSTYRIED**
SPECIFIC MATTERS FOR CONSIDERATION

4.1 **Summary of Business Considered in Private**

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below items were considered in private at the meeting held on

- AC26.22 Counter Fraud Progress Report
- AC26.23 Finance update
- AC26.24 Corporate Risk Register
- AC26.25 Centre for Mental Health and Society – Advisory Review

4.2 **Committee Forward Work Plan**

4.2.1 The Forward Work Plan (Appendix A) sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

4.3 **Breaches to the Standing Orders relating to the late publication of papers**

4.3.1 the total number of breaches to the Standing Orders relating to the late publication of papers is 9, these are detailed in the table below:

Board / Committee	Date of Meeting	Date Papers Published	Date Late Paper Published	Reason for Breach / Later Paper	Item Ref Number & Title of Paper
Quality Safety Experience	15.01.26	08.01.26	12.01.26 (4 days after publication) **Breach**	Required further review and amendments	QS26.10 Challenged Services Update
Board	27.11.25	21.11.25	25.11.25 (4 days after publication) **Breach**	Required further review ahead of Executive sign off	25.203 CEO Report
Board	25.09.25	18.029.25	22.09.25 (4 days after publication) **Breach**	Required further review ahead of Executive sign off	25/171 Strategic Planning a) Key Programmes Report 25/172 Foundations for the Future Report changed from paper to presentation so no breach
Planning Population Health Partnership	04.09.25	28.08.25	01.09.25 (4 days after publication) **Breach**	Additional paper requested by Pam Wenger	PP25/77 Winter Resilience Planning 2025/26 including presentation
Performance Finance and Information Governance	26.08.25	19.08.25	21.08.25 (2 days after publication) **Breach**	Required further review	PF25.69 Urgent and Emergency Care Papers
Board	31.07.25	24.07.25	28.07.25 (4 days after publication) **Breach**	Required further review ahead of Executive sign off	25/130 Integrated Performance Report
People and Culture	12.06.25	15.06.25	20.06.25 (5 days after publication) **Breach**	Carol Shillabeer requested the paper to be amended.	PC25/56 Fair Work Element of the Well-being Objectives
Board	29.05.25	22.05.25	27.05.25 (4 days after publication) **Breach**	Required further review ahead of Executive sign off	25/88 Foundations for the Future
Board	29.05.25	22.05.25	27.05.25 (4 days after publication) **Breach**	Required further review ahead of Executive sign off	25/91 Staff Engagement and Experience Report

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

5.1 There are no matters for escalation.

6 ARGYMHELLION
RECOMMENDATIONS

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

- **NOTE** the matters considered in Private at the 17 February 2026 meeting.
- **NOTE** the Committee forward workplan.
- **NOTE** the breaches to the Standing Orders relating to the late publication of papers

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 1. Building an effective organisation
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	BAF24-01 Building an Effective and Accountable Organisation

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Not necessary for this report

Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)	If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd Enablers of Quality** All Apply	**Meysydd Ansawdd Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
	Do/Yes: ☐	Naddo/No: ☒

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

Audit Committee – Non-Routine Committee Business Workplan

(1 April 2024 – date)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
20.3.26	Action QS26.38.2 Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	QSE Committee	Implementation of the Learning Repository	Update to be provided to the Audit Committee for assurance	Angela Woods	Executive Director Nursing and Midwifery	June 2026	In progress
29.07.25	Action AC25/32.1 from Audit Committee	Pam Wenger	Information Governance and Records Management	A session on records management to take place with the Executive Committee and come back to the Committee as a substantive item.	Dylan Roberts	Pam Wenger	16.12.25	Being discussed with the DDaT team how to take this forward
21.07.25	Action AC25/70.1 from Audit Committee 08.05.25	Pam Wenger	Clinical Audit Improvement Plan	Clinical Audit Plan to go to QSE in July and come back to Audit Committee to confirm progress.	Joanne Shillingford	Clara Day	16.12.25	CLOSED received
16.01.25	Audit Committee action AC25/05.4	Audit Committee	Final Internal Audit Report on Consultant Job Planning	Progress and oversight to be monitored by the People and Culture Committee referring back to the Audit Committee in six months' time.	Sree Andole Nick Graham	Pam Wenger	16.12.25	CLOSED - received
08.01.25	Action AC24/151.1 from Audit Committee	Pam Wenger	Review of Centre for Mental Health and Society (CfMHaS) / Report on FOI Request Email from PM 01.07.25 still in the procurement stage so report not due to be ready until end of August	A full evaluation report to be presented at Audit Committee – this was due to go to Jan / March but put forward for April meeting as the review will be commissioned externally.	Phil Meakin	Pam Wenger	16.12.25	CLOSED reeceived
04.03.25	Suggested as part of discussion at meeting 04.03.25	Pam Wenger	Standing Orders Reservation and Delegation of Powers	Full review of Standing Orders Reservation and Delegation of Powers	Philippa Peake-Jones	Pam Wenger	19.08.25	**CLOSED** Going to Comm in Aug 25
12.06.25	Email from PW / TA	Pam Wenger	Audit Wales Planned Care Report	Management response on the Planned Care report to be presented to the Committee.	Tehmeena Ajmal Russell Caldicott	Tehmeena Ajmal Russell Caldicott	19.08.25	**CLOSED** Going to Comm in Aug 25
17.06.25	Email from PW / RC	Pam Wenger	Historical Symphony Contract	Paper to be presented in private	Alison Bishop producing paper	Russell Caldicott	19.08.25	**CLOSED** Going to Comm in Aug 25
31.03.25	Email from Danielle Timmins 31.03.25	Danielle Timmins	Counter Fraud Annual Report	Counter Fraud Annual Report to go to Audit Committee in June 25.	Danielle Timmins	Russ Caldicott	24.06.25	**CLOSED** Went to Comm in June 25
16.01.25	Audit Committee item AC25/04	Audit Committee	The Role of Internal Audit	The video developed has been shared at the AC Development Session in Feb 25 and an update to be provided to the April meeting in relation to the Comms plan and revised video.	Glesni Driver Dave Harries	Pam Wenger	30.04.25	**CLOSED** Went to Comm in May 25

16.01.25	Action AC25/10.1 from Audit Committee	Audit Committee / Pam Wenger	Health Board Policies Report on overdue policies (not WCDs)	An update on HB Policies and WCDs went to the January meeting. A report focussing on overdue policies to go to the Committee in April.	Glesni Driver	Pam Wenger	30.04.25	**CLOSED** Went to Comm in May 25
25.02.25	Discussion with PW and PPJ re: March 25 agenda	PW & PPJ	Annual Report Compliance with the Corporate Governance Code	PPJ agreed with PW to put this forward from March 25	Philippa Peake-Jones	Pam Wenger	30.04.25	**CLOSED** Went to Comm in May 25

Audit Committee

CORPORATE GOVERNANCE IMPROVEMENT PLAN

Dyddiad y Cyfarfod **Date of Meeting**	21 April 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

This report provides the Audit Committee with an update on progress against the **Corporate Governance Improvement Plan 2025–27**, which sets out the Health Board's programme of work to strengthen corporate governance arrangements in response to internal and external review findings, including the Structured Assessment, Board Assessment, Internal Audit and Audit Wales reports.

The Corporate Governance Improvement Plan was previously considered by the Audit Committee in October 2025 and has now been fully embedded within the Health Board's programme management software to enable structured monitoring, reporting and executive oversight. The plan is aligned to Strategic Priority 1: Building an Effective Organisation and is organised across six key governance domains, including corporate governance, standards of business conduct, risk management, compliance, and procurement and financial governance. Each action has a named accountable lead, priority and delivery timescale.

Overall progress reflects continued implementation of the agreed governance improvement actions, with a number of actions completed and the majority progressing as planned. A small number of actions have reached or passed their agreed delivery dates and are highlighted within the report for assurance and oversight. These relate in particular to the Board self-assessment process,

simplification of the policy management system, and strengthened governance arrangements for procurement and the use of direct awards.

Governance recommendations arising from the 2025 Structured Assessment have been consolidated within the Corporate Governance Improvement Plan, providing a clear line of sight between external recommendations and the governance improvement actions being delivered during 2025/26. The report also outlines further steps being taken to strengthen procurement governance, including enhanced executive oversight, clearer escalation routes, and alignment with Standing Orders, Standing Financial Instructions and national procurement requirements.

The Audit Committee is asked to note progress against the Corporate Governance Improvement Plan, and to take assurance from the arrangements in place to monitor delivery, manage slippage where identified, and support continued strengthening of governance and assurance across the Health Board.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Executive Committee	8 April 2025	Approved

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

CORPORATE GOVERNANCE IMPROVEMENT PLAN

1. Y SEFYLLFA / SITUATION

1.1 The Draft Governance Improvement Plan 2025–27 set out a framework to strengthen governance across Betsi Cadwaladr University Health Board, aligned with Strategic Priority 1: Building an Effective Organisation. The plan responds to findings from internal and external assessments, including the Structured Assessment, Board Assessment, Internal Audit, and Audit Wales reviews.

1.2 The plan is structured around six key governance domains:

- **1..1** Corporate Governance
- **1..2** Standards of Business Conduct
- **1..3** Risk Management
- **1..4** Compliance (Reporting, Systems, Processes, and Policy Framework)
- **1..5** Procurement and Financial Governance
- **1..6** Each action is assigned to accountable leads with clear timelines, ensuring progress is monitored and aligned with strategic transformation programmes. This plan reflects the Health Board's commitment to continuous improvement, transparency, and delivering high standards of governance across all levels of the organisation.

2 Y CEFNDIR / BACKGROUND

2.1 The Audit Committee received the Draft Corporate Governance Improvement Plan in October 2025. This draft has now been uploaded into the Health Board's programme management software for clear monitoring and reporting.

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

3.1 A small number of actions within the **Corporate Governance Improvement Plan** have reached or passed their agreed due dates and are therefore highlighted for escalation and oversight:

Governance – Board Self-Assessment Process (Board Assessment)
"Review and refine the Board Self-Assessment process ensuring it evolves as part of Board feedback" (Owner: Head of Corporate Governance) also reached its due date of **30 March 2026** and is reported as **85% complete**. Finalisation is required to close this action.

Compliance – Policy Management System (Structured Assessment)
"Simplify the Policy Management System and reduce the number of overdue policies" (Owner: Head of Compliance & Inquiries) reached its due date of **30 March 2026** and remains **in progress** with **60**% completion **reported**, requiring further focus and assurance on delivery timescales.

Procurement and Contracting – Direct Awards Monitoring (Internal Audit)
"Reduce the number of Direct Awards through the introduction of robust systems of monitoring and escalation" (Owner: Executive Director of Finance) reached its due date of **30 March 2026** and is currently reported as **in progress** with **75% completion**, representing a key area for executive oversight given its link to financial governance and audit assurance.

3.2 The governance recommendations arising from the Structured Assessment for 2025 have been incorporated into the updated report to provide a clear line of sight to the governance improvements being progressed during 2025/26. These actions are consolidated within the Corporate Governance Improvement Plan, which sets out the agreed priorities, ownership and timescales for delivery and will be used to monitor progress and provide assurance.

3.3 The Health Board continues to strengthen its governance and assurance arrangements in relation to procurement activity, including the use of direct awards. Direct awards are recognised as a legitimate procurement route where permitted under national frameworks; however, their use is subject to enhanced governance controls to ensure transparency, value for money and compliance with Standing Orders, Standing Financial Instructions and national procurement regulations.

3.4 All direct awards are required to be supported by clear evidence, appropriate procurement advice and executive approval, with oversight from both the Executive Director of Finance and the Director of Corporate Governance. This approach supports a consistent and defensible decision-making process, reduces the risk of challenge, and provides assurance that procurement routes are applied proportionately and in line with the Health Board's Decision-Making Framework and wider governance arrangement.

3.5 As part of strengthening procurement governance and assurance, the **Procurement Team within NWSSP** will review a procurement guide for staff which will include the application of approved procurement routes, including compliance with national frameworks and internal controls. The current manual is available here.

4 An **executive-led Contracting and Commissioning Executive Delivery Group** will be established as part of the governance arrangements, providing

structured executive oversight of commissioning and contracting activity and a clear route for assurance and escalation to the Executive Committee.

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

5.1 There are no matters for escalation currently.

6 ARGYMHELLION
RECOMMENDATIONS

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

- **NOTE** the progress against the Corporate Governance improvement plan.

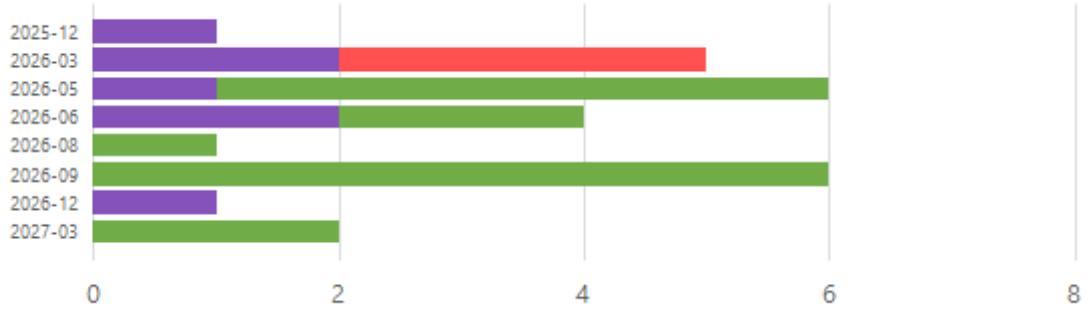
PROGRAMME PLAN REPORT

PROGRAMME TITLE: Effective Systems of Governance

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

SRO: Pam Wenger (BCUHB - Corporate Office)

10/04/26 10:43



Task Owner	Complete	In Progress	Overdue	Total
Carol Shillabeer (BCUHB - Corporate Office)	1	0	0	**1**
Catrin Rhys Williams (BCUHB - Corporate Office)	0	1	0	**1**
Ffion Johnstone (BCUHB - Corporate Office)	0	1	0	**1**
Glesni Driver (BCUHB - Corporate Office)	1	2	1	**4**
Jody Evans (BCUHB - Corporate Office)	0	1	0	**1**
Pam Wenger (BCUHB - Corporate Office)	2	4	0	**6**
Phil Meakin (BCUHB - Governance & Communications)	0	1	0	**1**

Philippa Peake-Jones (BCUHB - Corporate Office)	1	6	0	**7**
Russell Caldicott (BCUHB - Corporate Office)	2	0	1	**3**
Total	**7**	**16**	**3**	**26**

Workstream	Title	Assigned to	Status	Priority	Due Date	% Complete
Compliance (Reporting, Systems, Processes and Policy Framework)	The Health Board should increase the pace of its process to update high-risk policies (Structured Assessment Recommendation 2025)	Glesni Driver (BCUHB - Corporate Office)	In Progress	High	23/09/26	**0%**
	To simply the Policy Management System and ensure improvements are made in terms of the reduction of overdue policies (Structured Assessment)	Glesni Driver (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	**60%**
	Streamline and strengthen the reporting arrangements for Internal and External Audit Recommendations (Structured Assessment)	Glesni Driver (BCUHB - Corporate Office)	Complete	Medium	29/06/26	**100%**
	The Health Board should ensure that the Board receives JCC minutes and related assurance reports to enable it to discuss risks and implications of national commissioning arrangements (Structured Assessment	Philippa Peake-Jones (BCUHB - Corporate Office)	Complete	Medium	27/05/26	**100%**
Governance	To continue to evolve the Executive Committee arrangements by formalising the 'sub' groups and ensure that they are operating effectively (Structured Assessment)	Catrin Rhys Williams (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	**80%**

◆	Private Items at Board and Committee (Structured Assessment 2025)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	High	27/05/26	**58%**
◆	The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports) (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	High	27/05/26	**70%**
◆	Review the Operational Governance Framework as part of any changes to the 'operating model' as part of Foundations for the Future Programme (Foundations for the Future / Internal Audit Report)	Phil Meakin (BCUHB - Governance & Communications)	In Progress	Medium	31/08/26	**30%**
◆	To reflect on the Quality Governance reporting taking into consideration the recommendations from the Quality Governance Review by Audit Wales (Audit Wales)	Pam Wenger (BCUHB - Corporate Office)	In Progress	Medium	29/06/26	**50%**
◆	The Health Board should ensure that it has the appropriate programme management and governance arrangements in place to support the roll out of the Foundations for the Future Programme. (Structured Assessment)	Ffion Johnstone (BCUHB - Corporate Office)	In Progress	High	23/09/26	**0%**
◆	Through regular review of the Governance Framework; ensure that it is fit for purpose and is reviewed and refreshed as part of an annual review and as part of the	Pam Wenger (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	**80%**

	Foundations for Future Programme (Board Assessment)					
◆	Review induction process for all Board Members (Board Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	Medium	29/06/26	**50%**
◆	Improve the focus of Board formal and informal meetings to ensure the balance of the time spent by the Board on strategic discussions (Board Assessment)	Pam Wenger (BCUHB - Corporate Office)	In Progress	Medium	30/03/27	**50%**
◆	AAA Reports Publication within 14 days of the (Structured Assessment)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	High	27/05/26	**0%**
◆	Undertake and Annual Board Self Assessment	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	Medium	30/05/26	**85%**
◆	Continue to review and refine the business planning arrangements for Committees ensuring they are fit for purpose (Structured Assessment)	Pam Wenger (BCUHB - Corporate Office)	Complete	High	29/06/26	**100%**
◆	To ensure that all Corporate Directors attend procurement training and understand their roles (Internal Audit)	Carol Shillabeer (BCUHB - Corporate Office)	Complete	Medium	31/12/25	**100%**
Procurement and Contracting	◆ To reduce the number of Direct Awards through the introduction of robust systems of monitoring and escalation (Internal Audit)	Russell Caldicott (BCUHB - Corporate Office)	Complete	Medium	30/03/26	**100%**
	◆ Executive and Corporate Directors receive an update session on the requirements and expectations laid out in the Standing	Russell Caldicott (BCUHB - Corporate Office)	Complete	Medium	30/03/26	**100%**

	Financial Instructions and cascade this to their respective management teams. (Internal Audit)					
	Further embed risk management systems to ensure that risk is actively managed and demonstrable improvements in risk reduction are visible through the Corporate Risk Register (Internal Audit Reports / Structured Assessment)	Jody Evans (BCUHB - Corporate Office)	In Progress	Medium	29/09/26	**50%**
Risk Management	Review the Standing Financial Instructions to take into account the requirements of the Procurement Act 2023 and introduce a Procurement Guide for all Staff (Internal Audit Report)	Russell Caldicott (BCUHB - Corporate Office)	Overdue	Medium	30/03/26	**75%**
Standards of Business Conduct	Ensure all Directors and monitoring arrangements are in place for ensuring staff at Band 8C and above are completing their declarations of gifts and hospitality, including where such gifts and hospitality are declined (in accordance with the Standards of Business Conduct Policy) (Internal Audit Report)	Philippa Peake-Jones (BCUHB - Corporate Office)	In Progress	Medium	30/03/27	**76%**
	Progress recommendations made by Audit Wales Structured Assessment, Planned Care, Unscheduled Care etc.) (Audit Wales Report)	Glesni Driver (BCUHB - Corporate Office)	Overdue	Medium	30/03/26	**50%**
	A series of guidance documents be circulated to all Board Members and Budget Holders in respect of key conduct matters	Pam Wenger (BCUHB - Corporate Office)	Complete	Medium	31/12/26	**100%**

		such as declarations of interest and gifts and hospitality (Internal Audit Report)					

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Galluogwyr Ansawdd Enablers of Quality Choose an item.	

Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Choose an item.	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

Audit Committee

STANDARDS OF BUSINESS CONDUCT

Dyddiad y Cyfarfod Date of Meeting	21 April 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Assurance

**Crynodeb Gweithredol
Executive Summary**

This paper provides assurance that arrangements for managing Declarations of Interest are now operating effectively and in line with the Standards of Business Conduct, following the implementation of actions arising from Internal Audit findings. Reporting, scrutiny and accountability arrangements have been strengthened, with improved oversight of both Board Member and staff declarations and publicly accessible registers now in place. While assurance can be provided in relation to Declarations of Interest, further work is required to strengthen awareness, compliance and reporting for Gifts and Hospitality, which will be progressed as part of the Governance Improvement Plan during 2026. The Audit Committee is asked to note the progress made and seek assurance that ongoing monitoring will continue to strengthen transparency and compliance.

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

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

Executive Committee	8 April 2026	Approved

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
Declare	This is the software used to track Declarations of Interest

STANDARDS OF BUSINESS CONDUCT

1. Y SEFYLLFA
SITUATION

1.1 Declarations of Interest are a core component of the Health Board's governance framework and are critical to maintaining transparency, integrity and public confidence in decision-making. Recent Internal Audit work has identified weaknesses in the consistency and effectiveness of reporting and oversight arrangements, requiring strengthened assurance to the Board.

2 Y CEFNDIR
BACKGROUND

2.1 The Health Board's arrangements for Declarations of Interest are set out within the Standards of Business Conduct Policy, applying to Board Members and relevant staff. These arrangements include the completion of annual declarations, ad-hoc updates where interests change, maintenance of live registers, and routine scrutiny through the Audit Committee via the Corporate Governance Report.

2.2 Directors are individually and collectively responsible for ensuring that all decision-makers within their areas of accountability understand, comply with, and uphold the Health Board's Standards of Business Conduct and requirements for the declaration and management of interests. This includes ensuring that:

- All staff involved in decision-making, whether clinical, operational, financial or governance-related, are aware of their obligation to declare any personal, financial, professional or family interests that could, or could be perceived to, influence their judgement. This reflects the principle that the onus for declaring interests rests with the individual, as emphasised in the Standards of Business Conduct Policy.
- Decision-makers are reminded regularly of their responsibilities, including on appointment, annually, and whenever new interests arise, in line with the requirements placed on Board members within Standing Orders.

- Robust local arrangements are in place to support timely declaration, including annual prompts, directorate governance processes, and escalation routes where concerns arise.
- Directors ensure the accurate recording, maintenance and review of registers of interests relevant to their functions, and that any declared interests are appropriately considered and managed during decision-making processes (e.g. through recusal or alternative oversight).
- Directors promote a culture of openness and transparency, ensuring staff feel confident to declare interests and understand the implications of non-compliance.

2.2 Internal Audit undertook a review of Declarations of Interest, Gifts and Hospitality, the findings of which were reported to the Audit Committee. This review forms a key source of assurance, and a further Internal Audit has commenced.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 Internal Audit Findings

➢ Internal Audit concluded that, during 2023/24, reporting arrangements did not fully meet policy requirements. Specific issues identified included:

- Inconsistent submission and review of registers by the Audit Committee.
  - This has now been resolved by including an update to each Audit Committee via the Corporate Governance Report and a specific report on the matter twice per year (as per this paper).
- Limited scrutiny of staff declarations, with reporting focused largely on Board Members.
  - This has now been resolved as all declarations are signed off by Line Managers with further scrutiny being aligned to the new PADR forms. Declare Administrators receive a weekly update to note what additional declarations have been made, these are scrutinised.
- Identification of a small number of undisclosed Board Member interests, primarily relating to external directorships, which were not reflected in the published register at the time of review.
  - This has now been resolved; any new changes are tracked in red for audit purposes and the register is kept live.

3.2 Registers of Declarations of Interest

Below are the two registers of interest shared publicly, the first is that of Board Members the second is that of Employees who are 8c and above as defined in the Standards of Business Conduct Policy as those who should declare.

- Board Member Declarations can be found: bcuhb.nhs.wales/about-us/board-members/declerations-of-interest/register-of-board-members-declarations-of-interest-live-for-websitepdf1/?ts=1775043817950

- The current system of reporting declarations of interest and gifts and hospitality is an area of improvement that is highlighted in terms of the Corporate Governance Improvement Plan for 2025/26. This information provides a link to the register and going forward, it will be monitored by the Corporate Governance Team reporting on any breaches to the policy.

- Declarations for those 8c and above can be found here: https://bcuhb.mydeclarations.co.uk/declarations

  Whilst some progress has been made; the current reporting system makes it challenging to prepare reports to demonstrate compliance; whilst there is work being progressed in this area; there still needs to be a focus on ensuring decision makers are declaring in accordance with the Standards of Business Conduct Policy.

  Table 1 : Decision Makers (8c and above)

	Staff Count	Declarations Made	Staff that have not made a declaration	Total
2024/25	1975	1235	740	1407
2025/26	2407	1307	1100	1602

- Directors should actively champion and oversee the declaration of interests within their directorates, ensuring that all decision-makers understand their obligations and that robust systems are in place for timely, accurate, and transparent reporting. Specifically, Directors should:
- Regularly remind staff of their responsibility to declare any interests that could influence their judgement, both on appointment and annually, and whenever new interests arise.
- Promote a culture of openness and transparency, so staff feel confident to declare interests and understand the implications of non-compliance.

- Escalate any concerns or breaches to the Corporate Governance Team and Audit Committee for appropriate action.
- Monitor compliance rates and address gaps, particularly among senior staff (Band 8c and above), using data from the declarations system.

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

While work has taken place to improve the awareness of Declarations of Interests and a new way of reporting tailored to the Health Board will be developed during 2026, the reporting of Gifts and Hospitality requires more focus.

5 ARGYMHELLION RECOMMENDATIONS'

5.1 Gofynnir i'r Pwyllgor/
The Committee is asked to:

- **SEEK ASSURANCE** that ongoing monitoring and reporting will continue to strengthen compliance and transparency in relation to Declarations of Interest and Gifts and Hospitality.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm:	Not required

	If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Audit Committee

STATUTORY COMPLIANCE REPORT

Dyddiad y Cyfarfod **Date of Meeting**	21 April 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Draft Status - Final Version will be Published
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Glesni Driver, Head of Statutory Compliance and Inquiries
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Assurance

Crynodeb Gweithredol
Executive Summary

This report provides an update on the Health Board's statutory compliance position, drawing together assurance from internal and external audit activity, regulatory body reviews, policy management, and statutory inquiries. It reflects the findings of the structured assessment of compliance arrangements and highlights areas of progress alongside significant and ongoing risks that require strengthened Executive oversight.

The structured assessment confirms that audit tracking and closure arrangements remain a material area of risk. A significant number of Internal Audit and Audit Wales recommendations, including *unsatisfactory*, *limited* and high-priority actions, remain open and overdue against their original implementation dates, with several outstanding for more than six months. While a number of recommendations are now being progressed through the formal closure process and are presented for Audit Committee approval, overall progress continues to be constrained by delays in the submission of sufficient and timely supporting evidence. This limits the Health Board's ability to demonstrate effective governance, internal control and sustained compliance, and reinforces the need for stronger Executive grip on delivery and assurance.

Regulatory body reviews continue to be actively monitored through established governance arrangements. The structured assessment recognises that improvement actions arising from Healthcare Inspectorate Wales (HIW) inspections and Care Inspectorate Wales (CIW) reviews are progressing, with high levels of completion achieved in several areas. However, a small number of actions remain outstanding and require continued operational focus and Executive oversight to ensure timely closure and to prevent regulatory slippage.

Policy management remains a key area of weakness identified through the structured assessment. A number of corporate policies and other written control documents are overdue review, including those relating directly to patient safety. While actions are underway through the Executive Policy Oversight Group and supporting arrangements, the current position indicates insufficient pace and prioritisation in some areas. This presents a continuing compliance and assurance risk, as out-of-date policies undermine the Health Board's governance framework and its ability to evidence compliance with statutory and regulatory requirements. Further detail is set out in Section 6 of Annex A.

Statutory inquiry activity is expected to increase significantly during 2026. The UK Covid-19 Inquiry Module 3 report, published on 19 March 2026, includes ten system-wide recommendations relevant to Wales, alongside further actions arising from the Welsh Government's response to the Module 2 report on core decision-making and political governance. The forthcoming Thirlwall Inquiry report is also expected after Easter 2026. Collectively, these developments underline the importance of robust audit tracking, effective policy management and clear accountability to ensure the Health Board can respond promptly and provide assurance on implementation.

Overall, while progress has been made across a number of areas, the structured assessment confirms that statutory compliance remains an area of heightened organisational risk, particularly in relation to audit recommendation tracking and policy management. In light of these findings, and to strengthen assurance and Executive grip on delivery, it is proposed that the Chief Operating Officer attends the next meeting of the Audit Committee to provide direct assurance on operational oversight, delivery plans and timescales for achieving timely closure of outstanding audit actions and overdue policies.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Executive Committee	25/03/2026	Noted by Committee, with recommendations approved for progression through the closure process

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
HIW	Healthcare Inspectorate Wales
CIW	Care Inspectorate Wales
RAG	Regulatory Assurance Group
IHC	Integrated Health Community
ECRS	Enhanced Community Residential Services
MDT	Multi-Disciplinary Team
EPOG	Executive Policy Oversight Group
WCDs	Written Control Documents

STATUTORY COMPLIANCE REPORT

1. Y SEFYLLFA
SITUATION

1.1 This report provides an update on statutory compliance activities, including internal and external audits, compliance with regulatory body reviews, updates on policy management, and national inquiries.

2. Y CEFNDIR
BACKGROUND

2.1 The Health Board is required to comply with a wide range of statutory duties, regulatory requirements, and mandatory standards set out in legislation, statutory instruments, and directions issued by Welsh Ministers.

2.2 Statutory compliance requires the Health Board to:

- Act within its legal powers and duties as set out in primary legislation, including the *National Health Service (Wales) Act 2006* and associated regulations
- Comply with Welsh Ministers' Directions, All-Wales policies, and statutory guidance issued under legislation
- Meet regulatory requirements imposed by external regulators, including Healthcare Inspectorate Wales (HIW), Audit Wales, the Care Inspectorate Wales (CIW), and professional regulators
- Ensure systems of governance, risk management, and internal control are effective in securing compliance with legal and regulatory obligations
- Implement, maintain, and review policies and procedures that support compliance with legislation
- Monitor compliance and provide assurance to the Board through reporting, audit, and review mechanisms
- Respond appropriately to breaches of statutory requirements, including incident management, regulatory engagement, and implementation of improvement actions.

2.3 Statutory compliance is a collective responsibility, with the Board retaining ultimate accountability and senior leaders and managers responsible for implementation within their areas of responsibility.

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

The full Statutory Compliance Report is included in Annex A of this cover report.

3.1 The Audit Committee is asked to note the content of this cover Report and Annex A.

3.2 Internal Audit recommendations presented for Audit Committee closure approval are included in Section 4.2.2 of Annex A.

3.3 The recommendations published within the Module 3 UK Covid-19 Inquiry into the 'Impact of the Covid-19 pandemic on healthcare systems in the four nations of the UK'.

3.4 The Welsh Government's response to the UK Covid-19 Inquiry Module 2 2, 2A, 2B, 2C Report on 'Core Decision-Making and Political Governance'/

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

4.1 Actions Required by the Executive Team

4.1.1 The implementation of audit recommendations will contribute to the reduction of risks across a number of Health Board areas, therefore timely delivery of the necessary actions relating to those recommendations is imperative.

4.1.2 Having effective, up to date and accessible corporate policies, procedures and other written control documents promotes governance best practice, guide staff and minimise risks, therefore updating and reviewing these documents in a timely manner is imperative.

5. ARGYMHELLION
RECOMMENDATIONS

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

- **NODI/NOTE** the report
- **CYMERADWYO/APPROVE** the closure of the Internal Audit recommendations, as per Section 4.2.2 of Annex A.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	     4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Not applicable, other than those relating to individual regulatory body reviews and audit reports

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	No impact
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd	**Galluogwyr Ansawdd** **Enablers of Quality**	**Meysydd Ansawdd** **Domains of Quality** All Apply

A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd? **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Data to Knowledge	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

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

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

Contents

ANNEX A

BETSI CADWALADR UNIVERSITY HEALTH BOARD STATUTORY COMPLIANCE REPORT

1. INTRODUCTION

This report provides an update on statutory compliance activities, including internal and external audits, compliance with regulatory body reviews, updates on policy management, and national inquiries.

2. INTERNAL AUDIT

Internal Audit recommendations continue to present a material compliance risk. A significant number of **'*unsatisfactory*'**, **'*limited*'**, and **high-priority** recommendations remain open, with many overdue their original implementation dates and several overdue by more than six months.

Although a number of recommendations were submitted to the Executive Committee for approval, progress overall is constrained by **outstanding evidence** and **requests for additional assurance** that remain unmet. These delays are preventing timely closure, and limiting the Health Board's ability to demonstrate effective governance.

The position highlights the need for strengthened Executive focus to ensure actions are completed, evidence is submitted promptly, and overdue high-risk recommendations are addressed without delay.

2.1 Internal Audit – new audit reports

Table 1 below shows all the Internal Audit reports received up to 2nd March 2026.

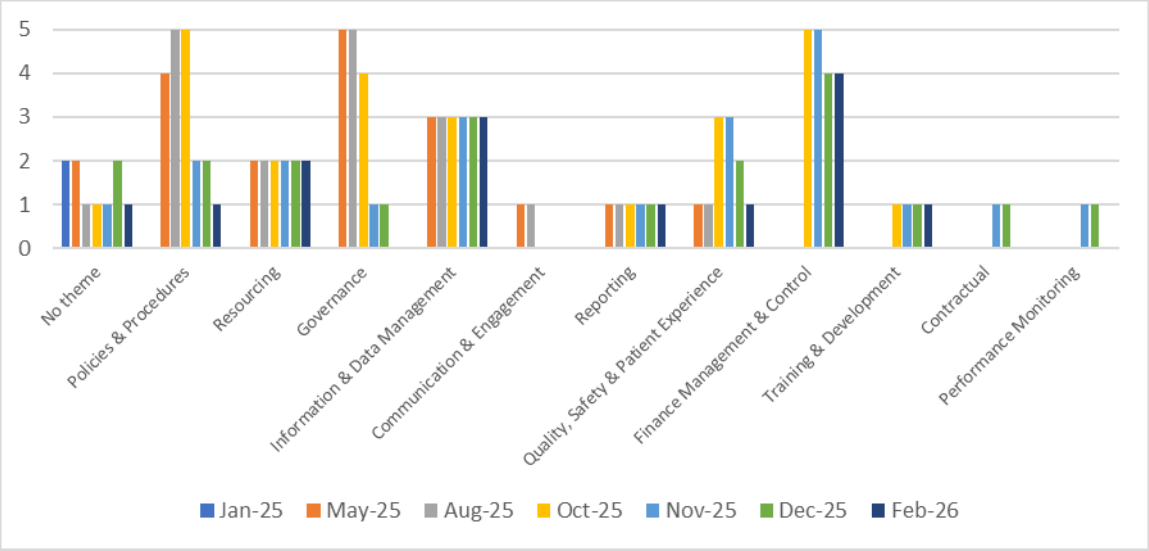
Reasonable	Primary Care – Contract Assurance Framework
Limited	Value and Sustainability – Delivering Quality Improvements
Limited	Estate Management – Estates and Facilities Alerts
Limited	On-call arrangements
Limited	National Institute for Health and Care Excellence (NICE) guidance compliance

2.2 Internal Audit – open '*Unsatisfactory*' assurance recommendations

Table 2 summarises all open *'unsatisfactory'* assurance recommendations by Executive, highlighting those overdue against their original implementation date. It also shows the total number of high-priority recommendations overdue by more than six months as at 2nd March 2026.

Executive Lead	'Unsatisfactory' assurance recs - open	Open 'unsatisfactory' assurance recs overdue original implementation date	High priority recs overdue original implementation date by 6 months or more
Chief Executive	1	1	1
Executive Medical Director; Deputy Director of People	5	5	5
Executive Medical Director	2	1	1
Executive Director of Finance	4	4	1
Chief Operating Officer	2	2	1
Total	**14**	**13**	**9**

Graph 1 below shows the open '*unsatisfactory*' recommendations per theme since January 2025.



A copy of all open '*unsatisfactory*' assurance recommendations is included in Appendix 1.

2.3 Internal Audit – open '*Limited*' assurance recommendations

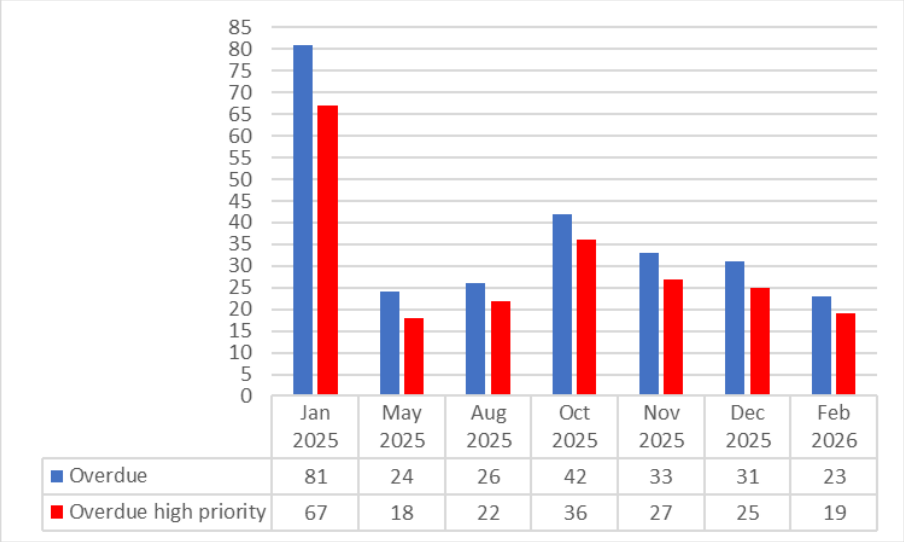
Table 3 summarises, by Executive, all open '*limited*' assurance recommendations as at 2nd March 2026, including: the total number open, those overdue, and high-priority recommendations overdue by more than six months.

Executive Team Member	Total 'Limited' assurance recs - Open	Open 'Limited' assurance recs overdue original implementation date	High priority recs overdue original implementation date by 6 months or more
Executive Director of Nursing and Midwifery	3	2	1
Chief Operating Officer	1	0	0
Deputy Director of People	0	0	0
Director of Corporate Governance	12	4	0
Executive Director of Finance	13	9	5
Executive Director of Finance; Director of Corporate Governance	1	0	0
Executive Medical Director	0	0	0
Executive Medical Director; Deputy Director of People	1	1	0
Executive Director of People Services and Organisational Development	1	1	0
Chief Digital and Information Officer	2	0	0
Director of Partnerships, Engagement and Communications	2	2	0
Executive Director of Public Health	2	2	0
Director of Environment and Estates	4	4	4
Total	**42**	**25**	**10**

A copy of all open '*limited*' assurance recommendations is included in Appendix 2.

2.3.1 High priority '*limited*' recommendations

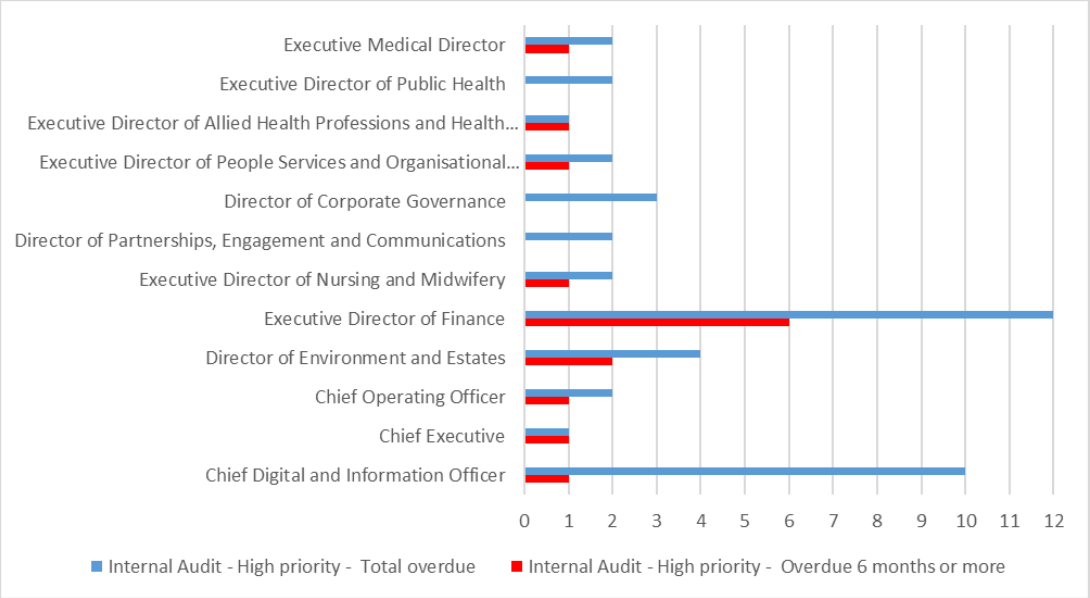
Graph 2 below shows all overdue '*limited*' assurance recommendations since January 2025, and of those overdue, the 'high priority' total. Even though this shows a marked improvement in the number of high priority '*limited*' assurance recommendations overdue their original implementation date over the last 12 months, this is still not an acceptable level.



	Jan 2025	May 2025	Aug 2025	Oct 2025	Nov 2025	Dec 2025	Feb 2026
Overdue	81	24	26	42	33	31	23
Overdue high priority	67	18	22	36	27	25	19

2.4 Internal Audit - open and overdue 'high priority' recommendations

Graph 3 below provides details of all open 'high priority' Internal Audit recommendations overdue the original implementation, and the number overdue by 6 months or more (as at 2nd March 2026), listed by lead Executive Team Member.



3. AUDIT WALES

3.1 Audit Wales – new audit reports

No new Audit Wales reports have been published since the last update (correct at 2nd March 2026).

3.2 Audit Wales – open recommendations

Table 4 below shows the number of Audit Wales recommendations overdue their original implementation date by 6 months or more (as at 2nd March 2026):

Report Title	Number overdue original implementation date - 6 months or more	Lead Executive Team Member
Structured Assessment 2022	1	Chief Digital and Information Officer
Structured Assessment 2024	2	Director of Corporate Governance
Review of Cost Savings Arrangements	2	Executive Director of Finance
Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2	Chief Operating Officer
Total	**7**	

The details of all the open Audit Wales recommendations are included in Appendix 3.

4. AUDIT SUMMARY

4.1 All recommendations

Table 5 below provides a summary of all new recommendations received, correct as at 2nd March 2026.

	As at 14/03/2025	As at 24/04/2025	As at 29/07/2025	As at 29/07/2025	As at 02/10/2025	As at 31/12/2025	As at 02/03/2026
New Internal Audit recommendations	46	60	98	20	20	18	17
New Audit Wales recommendations	8	24	0	0	17	22	0

4.2 Internal Audit

4.2.1 Internal Audit – for Executive closure approval

Table 6 shows the number of Internal Audit recommendations awaiting lead Executive Team member approval for closure.

Executive Lead	Awaiting closure approval from Executive
Chief Operating Officer	2
Total	**2**

Appendix 4 provides the detail of the recommendations awaiting Executive closure approval.

4.2.2 Internal Audit – for Audit Committee closure

Appendix 5 provides details of the Internal Audit recommendations being presented to the Audit Committee for closure approval. These are a combination of recommendations:

- that fall outside this review scope for Internal Audit
- that have received approval for closure by Internal Audit, but now need final closure approval by the Audit Committee.

4.2.3 Internal Audit – recommendations requiring closure supporting evidence

A number of recommendations require further evidence to support closure, and a request for this evidence has been made. However, the supporting evidence has not been forthcoming in the majority of cases, therefore escalation meetings with the Corporate Governance Directorate will now be held with the lead Executive Team members to progress the evidence required for these recommendations. These meetings will be arranged over the coming weeks.

4.2.4 Internal Audit – recommendations requiring additional evidence following audit body review

As per the update in 4.2.3 above, escalation meetings will now be held with the lead Executive Team members to progress the evidence required for

these recommendations. These meetings will be arranged over the coming weeks.

4.3 Audit Wales

4.3.1 Audit Wales – recommendations for Audit Committee approval

There are no Audit Wales recommendations put forward for Audit Committee closure approval.

4.3.2 Audit Wales – recommendations for Executive review

Table 7 shows the number of Audit Wales recommendations awaiting lead Executive Team member approval for closure.

Executive Lead	Awaiting closure approval from Executive
Chief Operating Officer	2
Total	**2**

Appendix 6 provides the detail of the recommendations awaiting Executive closure approval.

4.4 Audit - Re-profiling of historic and unmanageable items

The Corporate Governance Directorate has not been made aware that there are any recommendations that need consideration as no longer relevant.

4.5 Realignment of audit recommendations

There has been no realignment of audit recommendations since the last report.

5. REGULATORY BODY REVIEWS (NON-AUDIT BODIES)

5.1 HEALTHCARE INSPECTORATE WALES

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance, and regulations to highlight areas requiring improvement. HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

The Quality Assurance Team continue to work with clinical areas to progress action plans, the below are all open HIW improvement plans, with targeted plans to progress completion.

Inspection – Ysbyty Gwynedd Emergency Department (14-16 April 2025)

- **Status:** Overdue
- **Recommendations:** 28
- **Actions:** 66 total; 64 completed (97%)
- **Outstanding:** 2 actions remain
- **Closure Date:** Revised to February 2026
- **Governance:** Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

Inspection – Cemlyn Ward, Ysbyty Cefni (28-29 July 2025)

- **Status:** Overdue
- **Recommendations:** 19
- **Actions:** 41 total; 40 completed (98%)
- **Closure Date:** Revised to February 2026
- **Governance:** Progress monitored through T4 Programme Group, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG)

Inspection – Hergest Ward, Ysbyty Gwynedd (6-8 September 2025)

- **Status:** In progress
- **Recommendations:** 26
- **Actions:** 47 total; 28 completed (60%)
- **Closure Date:** 31st May 2026

- **Governance:** Progress monitored through Local HIW Review Meeting, T4 Programme Group, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG)

Requests for Assurance: The Health Board responded to requests for assurance from HIW concerning; Heddfan Unit (IHC East), T Block Entrance, Ysbyty Gwynedd, (IHC West), Ward 9, (IHC Central), Community Mental Health, (IHC Central), Ogwen Ward (IHC West) and Ward 12 (IHC Central).

In each case the improvement actions were detailed and HIW were assured by the Health Board response.

Concerns / Requests for Assurance (6)

- **Heddfan Unit, IHC East (Dec 2025)**
  HIW have requested assurance following concerns received relating to staffing levels, neglect of person-centred care, inappropriate comments about the patient and absence of Ward Manager

- **T Block Entrance, IHC West (Dec 2025)**
  Assurance request from HIW highlighted concerns around staff and patients being exposed to second hand smoke outside the main entrance of T Block entrance

- **Ward 9, IHC Central (Dec 2025)**
  Assurance request from HIW in relation to patient care

- **Community Mental Health Conwy (Jan 2026)**
  Assurance request from HIW in relation to safety and wellbeing of a patient

- **Ogwen Ward, IHC West (Jan 2026)**
  Assurance request from HIW in relation to staffing levels, standards of care, dignity and respect, insignificant rehabilitation, communication, poor management and safety issues

- **Ward 12, IHC Central (Jan 2026)**
  Assurance request from HIW in relation to governance oversight, concerns, staffing, leadership visibility and escalation routes.

5.2 CARE INSPECTORATE WALES

A Quality-of-Care Review for Enhanced Community Residential Services (ECRS) on both 4th July 2025 and 24th November 2025 found no immediate concerns and noted no areas for improvement. The service is progressing well with its improvement plan, which is on track for closure in March 2026.

The next visit is scheduled for 23rd February 2026, of which the outcome will be reported to the Regulatory Assurance Group.

5.3 QUALITY PEER REVIEWS

An exception-based Trauma Network Peer Review, identified gaps in BCUHB transfer documentation, inconsistent MDT communication, and a need for clearer governance. An improvement plan is currently in place with the Health Board Trauma Network team/ IHCs to address these findings. The improvement plan is being monitored through the Regulatory Assurance Group and the service are being supported to progress by the Quality Assurance Team.

5.4 PUBLIC SERVICES OMBUDSMAN FOR WALES

5.4.1 **Final Public Interest Report (Escalated):** There is an outstanding action related to the Commissioning Assurance Framework (CAF). This unfortunately missed the deadline. This is being tracked and monitored and will be subject to Executive approval and discussion with the Office of the Chief Executive.

5.4.2 **New Draft Public Interest Report:** A Draft Public Interest report has been received in January 2026. Subject to consideration of any points which the Health Board or the complainant make in response to the draft report, the Ombudsman considers that this case raises issues of public interest. The draft report has been shared with IHC Directors. The Health Board has responded to the Ombudsman accepting the report and agreed to implement all the recommendations. An action plan has been drafted in preparation for when Ombudsman's final report is issued.

6. POLICY MANAGEMENT

6.1 Executive Policy Oversight Group approvals

Table 8 below lists the policy reviewed and approved by the Executive Policy Oversight Group (EPOG) since the last update. Once approved, this policy will be published on BetsiNet by the Statutory Compliance Team, pending any actions from the Group being completed. The Group is chaired by the Director of Corporate Governance.

Policy	Policy Name	Lead Executive Team Member
MHLD 0032	Review of Detention or CTO by the Managers Discharge Panel	Director of Corporate Governannce
COM02	Betsi Cadwaladr University Health Board (BCUHB) Operational Procedure for Responding to Representations from Llais, The Citizen Voice Body for Health and Social Care in Wales	Director of Partnerships, Engagement and Communication

6.2 High-risk overdue policies update

The Audit Committee requested an update on overdue policies that posed the highest risk to the Health Board. All policies overdue their review date pose a risk to the Health Board, however, those relating to 'patient safety' were identified as those posing the highest risk as there is a potential direct impact on the safety of patients. The Statutory Compliance Team has undertaken an ongoing review and request for updates on progress around policies overdue a review.

Table 9 below provides details of the overdue policies relating to patient safety as at 5th March 2026. This is a reduction of 3 from the previous update.

Name	Policy type	Review Date	Responsible Directo
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	Policy	01/09/2019	Chief Operating Officer
MM05 - Intrathecal Chemotherapy Policy - V3.pdf	Policy	01/03/2021	Executive Medical Director
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	Policy	01/05/2021	Executive Medical Director
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	Policy	01/09/2021	Executive Medical Director
MM02 - Injectable Medicines Policy.pdf	Policy	08/07/2022	Executive Medical Director
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	Policy	01/12/2022	Chief Operating Officer
MM01 - BCUHB Medicines Policy.pdf	Policy	31/12/2023	Executive Medical Director
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	Policy	01/08/2024	Chief Operating Officer
PC_01 - BCUHB Patient Access to Planned Care Policy - Cymraeg.pdf	Policy	30/07/2025	Chief Operating Officer
RES03 - Cardiopulmonary Resuscitation (CPR) Policy.pdf	Policy	31/08/2025	Executive Medical Director
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy) .pdf	Policy	01/09/2025	Executive Medical Director
NU33 - All Wales Thromboprophylaxis Policy.pdf	Policy	01/11/2025	Chief Operating Officer
PC_01 - BCUHB Patient Access to Planned Care Policy .pdf	Policy	30/01/2026	Chief Operating Officer
OTD-01 - BCUHB Organ & Tissue Donation Policy.pdf	Policy	01/02/2026	Executive Director of Allied Health Professions and Health Science

Appendix 7 provides a full list of all overdue policies as at 5th March 2026, and progress updates provided up to that date, where provided.

6.3 Overdue procedures and written control documents

The Statutory Compliance Team continues to work with lead Executive Team Members to progress overdue procedures and other written control documents (WCDs). WCDs includes all procedures, guidelines, procedures, protocols, strategies and 'other' documents currently listed on the Policy Management System.

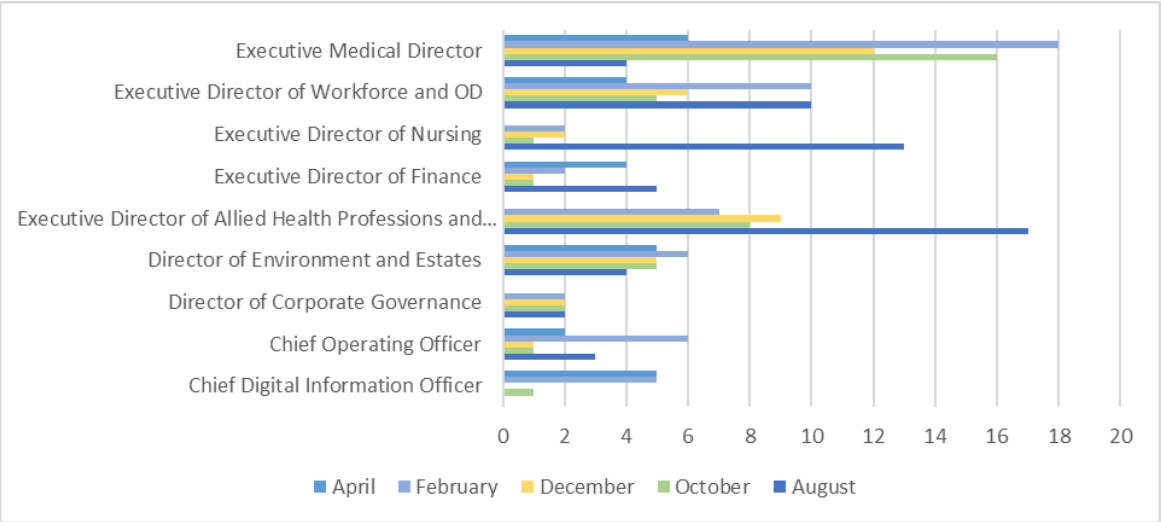
6.4 Overdue policy-documents – by Executive

Table 10 below provides the total number of all overdue policies and WCDs, which include all-Wales documents.

	Policy Overdue	WCD Overdue
Chief Digital Information Officer	5	3
Chief Operating Officer	2	32
Director of Corporate Governance	0	4
Director of Environment and Estates	5	2
Executive Director of Allied Health Professions and Health Science	4	23
Executive Director of Finance	0	1
Executive Director of Nursing and Midwifery	2	16
Executive Director of Public Health	0	1
Executive Director of Workforce and Organisational Development	4	6
Executive Medical Director	6	39
	28	**127**

6.5 Overdue WCD-documents – by Executive

Graph 4 below provides a comparison of the number of overdue WCDs, by lead Executive Team Member, which include all-Wales documents.



Please note that the dates in the key refers to Audit Committee meetings.

7. STATUTORY INQUIRIES

7.1 UK Covid-19 Inquiry

7.1.1 Module 10 – Impact of the pandemic on society

The investigation into the impact of the pandemic on society (Module 10) finished at the beginning of March 2026. This concludes the hearings for all ten modules of the Inquiry.

7.1.2 Module 3 – Impact of the Covid-19 pandemic on healthcare systems in the four nations of the UK

The Module 3 report was published on 19th March 2025, and brings together the findings and recommendations following evidence gathered over the course of Module 3 including at the oral hearings (9th September 2024 to 25th November 2024). The oral evidence was received from a wide range of people including senior politicians, healthcare leaders, scientific experts and some of those affected by Covid-19. The written material included expert reports, documents shared with the Inquiry, witness statements and the 'Every Story Matters' record. For the first time, this Report includes some of the experiences and anonymised quotes from those who shared their stories via 'Every Story Matters'.

The Report concludes that the UK entered the pandemic ill-prepared and with its overstretched healthcare systems in a precarious state. The impact of the pandemic on them was devastating, and the Report summarises this as 'they coped, but only just'. Healthcare systems came close to collapse, with that collapse only narrowly avoided because of the extraordinary efforts of all those working in healthcare across the UK, which shows remarkable commitment and dedication.

7.1.3 Summary of Module 3 Recommendations

The Report, which totals over 400 pages in length makes ten system-wide recommendations, all of which apply to Wales. These are provided below, including a headline summary.

Recommendation 1 - Strengthen Infection Prevention and Control (IPC) Structures

- Create a standing IPC body ready for immediate activation in pandemics
- Must have clear governance, multidisciplinary membership including aerosol science, and precautionary guidance assumptions

- Wales (Public Health Wales and Welsh Government) must review and update IPC manuals accordingly.

Recommendation 2 - Create Clear, Compassionate Visiting Restriction Guidance

- UK-wide framework for applying, escalating, and removing visiting restrictions
- Must use least-restrictive principles, applied as locally as possible
- Include clear rules for essential carers and birthing partners
- Review every 3 years.

Recommendation 3 - Increase Fit-Testing Capacity for Respiratory PPE

- Governments must expand the number of qualified fit-testers
- HSE must update guidance to ensure fit-testing is available at adequate scale.

Recommendation 4 - Improve Data Systems to Identify High-Risk Individuals

- Enable granular diagnostic coding, compatible records across services, and secure data-linkage
- Ensure rapid identification of clinically vulnerable people.

Recommendation 5 - Plan for Surge Capacity in Urgent and Emergency Care

- Governments must prepare scalable workforce plans for 111/999, Emergency Departments, and urgent care
- Plans should be published and reviewed every 3 years.

Recommendation 6 - Ensure Hospital Capacity Can Be Rapidly Expanded

- Health Boards must maintain up-to-date critical care expansion plans (power, oxygen, ventilation, workforce)
- Plans must be tested through exercises.

Recommendation 7 - Publish a UK-Wide Framework for Allocating Intensive Care Resources

- A national ethical and operational framework for Intensive Care Unit (UCU) triage when services are saturated
- Must include triggers, clinician legal duties, and routine review.

Recommendation 8 - Systematically Record Healthcare Worker Deaths

- Governments must create mechanisms to record, analyse, and publish healthcare worker deaths
- Data must be comparable across all UK nations.

Recommendation 9 - Create a UK-Wide Standardised Advance Care Planning Process

- Introduce a single national process (eg ReSPECT) for advance care discussions and DNACPR
- Wales currently uses its own forms; alignment is recommended.

Recommendation 10 - Deliver Scalable Psychological Support for Healthcare Workers

- Governments must ensure psychological support programmes are in place from the outset
- Peer support visits should be deployed to hard-hit hospitals.

7.1.3.1 Overall Themes for Wales

The recommendations repeatedly highlight Welsh needs in:

- Data and digital infrastructure
- Ventilation and estate improvement
- Fit-testing and PPE equity
- Workforce surge planning
- Advance care decision-making clarity
- Psychological support for staff

7.1.4 Publication of other Inquiry reports

The publication of the Module 4 report on Vaccines and Therapeutics on 16th April 2026. These reports follow public hearings held in September, November 2024 and January 2025.

Summer 2026 will see the publication of the Module 5 report, examining Procurement. Towards the end of the year, reports will be published for Module 6, investigating the Care Sector and Module 7, investigating Test, Trace and Isolate.

The remaining three reports, for Module 8 (Children and Young People); Module 9 (Economic response) and Module 10 (Impact on Society) will be published in the first half of 2027.

There will likely be recommendations and learning for the Health Board from a number of these module reports, but the one which is directed specifically to the Health Board is Module 3 (Healthcare Systems). With this in mind, arrangements are already in place to receive and respond to this and any other Inquiry reports when published via the Discovery and Learning Steering Group, chaired by the Executive Director of Nursing and Midwifery.

7.1.5 Welsh Government response to Module 2 - Core decision-making and political governance

The Module 2 report was published on 20th November 2025, and reflects the evidence heard in Module 2, which considered, for each of the four nations of the UK, the initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with devolved governments.

Module 2 examined these matters in respect of the UK Government, whilst Modules 2A, 2B and 2C were individual modules which examined the same matters from the perspective of Scotland, Wales and Northern Ireland respectively, with hearings held in each nation. The Welsh Government submitted more than 70 witness statements to this Module and 14 Welsh Government witnesses provided evidence at the oral hearings held in Wales in February and March 2024.

The Welsh Government has accepted the majority of the Inquiry's recommendations and is implementing a programme of work to strengthen Wales' resilience and emergency response structures. Health Boards will be expected to contribute to and operate within these revised frameworks.

The Module 2 Report emphasises:

- The need for transparent, evidence-based decision-making
- Improved identification of at-risk groups
- Faster access to health data during emergencies
- Consistent equality impact assessment processes
- A new taskforce model for whole-system emergencies.

The Welsh Government recognises that several of the recommendations contained in the Module 2 report, particularly those relating to intergovernmental structures, relations, communications and emergency decision making structures require collaboration. In developing their response to the Module 2 report, the Welsh Government has worked closely with the UK Government, the Scottish Government and the Northern Ireland Executive.

The Welsh Government's response sets out significant changes to emergency preparedness, scientific advice, data sharing, equality considerations, and decision-making structures. Health Boards, as Category 1 responders, will be expected to adapt their governance, operational readiness, data systems, and partnership arrangements to align with these new expectations.

The Welsh Government has already begun implementing changes through the Wales Resilience Framework, the Concept of Operations, and Exercise Pegasus.

The Health Board is currently reviewing the Welsh Government's response to the Module 2 report, and has identified a number of key actions as follows:

7.1.5.1 **SCIENTIFIC AND TECHNICAL ADVICE**
(Recommendations 2–5)

- Strengthen internal scientific advisory capacity
- Identify staff who may contribute to the Welsh expert register
- Put in place support for staff participating in advisory groups.

7.1.5.2 **IDENTIFYING AND SUPPORTING AT-RISK GROUPS**
(Recommendation 8)

- Strengthen systems for identifying clinically vulnerable individuals
- Embed equality and vulnerability considerations in emergency planning
- Participate in multi-agency structures focused on inequalities
- Improve data sharing and analytical capability.

7.1.5.3 **GOVERNMENT DECISION-MAKING AND TASKFORCES**
(Recommendations 10–12)

- Align Health Board emergency structures with the national taskforce model
- Ensure representation of vulnerable groups in decision-making
- Strengthen contingency arrangements for leadership continuity.

7.1.5.4 **LEGISLATION AND EMERGENCY POWERS**
(Recommendations 15–16)

- Prepare for strengthened scrutiny and reporting requirements
- Ensure operational readiness for rapid regulatory changes.

7.1.5.5 **INTERGOVERNMENTAL WORKING (Recommendations 18–19)**

- Strengthen multi-agency coordination
- Ensure readiness to support four-nations coordination.

7.1.5.6 **PUBLIC COMMUNICATION (Recommendations 14 and 17)**

- Ensure all emergency communications are accessible
- Align with national communication principles
- Use GOV.WALES as the single authoritative source.

7.1.5.7 **Discovery and Learning Steering Group**

As there is already an established Discovery and Learning Steering Group in place, chaired by the Executive Director of Nursing and Midwifery, the majority of these actions will be progressed through that Group, in response to and in consultation with the Welsh Government.

7.1.5.8 **Civil Contingencies Assurance Group**

Also, there is a well-established Civil Contingencies Assurance Group, chaired by the Executive Director of Public Health, and therefore the EPRR related recommendations should be progressed in response to and in consultation with the Welsh Government.

7.2 Thirlwall Inquiry

As per the previous update, publication of the Inquiry report is scheduled for after Easter 2026.

APPENDICES

APPENDIX 1 – INTERNAL AUDIT – OPEN '*UNSATISFACTORY*' ASSURANCE RECOMMENDATIONS

APPENDIX 2 – INTERNAL AUDIT – OPEN '*LIMITED*' ASSURANCE RECOMMENDATIONS

APPENDIX 3 – AUDIT WALES – OPEN RECOMMENDATIONS

APPENDIX 4 – INTERNAL AUDIT – RECOMMENDATIONS AWAITING EXECUTIVE CLOSURE APPROVAL

APPENDIX 5 – INTERNAL AUDIT – FOR AUDIT COMMITTEE CLOSURE APPROVAL

APPENDIX 6 – AUDIT WALES – RECOMMENDATIONS AWAITING EXECUTIVE CLOSURE APPROVAL

APPENDIX 7 – POLICY MANAGEMENT – ALL OVERDUE POLICIES

OPEN 'UNSATISFACTORY' AUDIT RECOMMENDATIONS

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Update at 24/02/2026
0457	Operating Model	2024	Unsatisfactory	High	Matter Arising 2: Operational Governance and Accountability Framework (Design and Operation)	2. The Health Board reviews its Governance and Accountability Framework to ensure it provides the necessary scrutiny and assurance from Ward to Board and vice versa.	2. As part of the organisational structure review, all accountability frameworks will be reviewed	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2026	2	The Governance Framework is in development as part of the Foundations for the Future Programme
1431	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.1 **Medical Resourcing** Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of	2.1 Provide comprehensive training for consultants and managers on job planning processes, focusing on linking individual objectives with organisational goals.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Training on Allocate for operational teams continueing. Roadshows on hold until All Wales guidance shared
1432	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	2.2 **Medical Resourcing** Through discussion with all clinical directorates/divisions, each advised on the limited support available to them in relation to Medical and Dental Contract matters, following the removal of a dedicated medical staffing resource. We have confirmed this was absorbed in 2019. The Office of the Medical Director is responsible for some people related functions, with limited contingency arrangements in the event of annual leave/prolonged absence. There is possibility of duplication within the Health Board through the operation of standalone people systems and development of	2.2 Establish clear communication channels for escalating job planning concerns or discrepancies.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Process for escalation will be included in the 'best practice' guide that is being developed. Previous escalation processes to be reviewed and shared as interim SOPs
1435	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.1 **Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in	4.1 The system is web based so accessible anywhere and backup by Allocate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			Updated that Business Contingency team had been contacted. As it is a cloud based system, no need to have a contingency plan in place.

1436	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.2 **Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in place locally.	4.2 Testing and approval of Medical Dental and Elements report from ESR (sessional payments) which will all periodically audits to verify that job plans reconcile with system records and ensure session payments are accurate.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			The Dashboard and Dashboard testing is complete with the task and finish group. A SOP and how to guide has been produced to support user in understanding the Dashboard parameters and how to use the Dashboard. All products were discussed at MWG 18/2/26, the papers and rollout were supported by MWG/Chair in principle, however, the group requested further assurance testing to be completed, with final sign off following testing of SOP. This is scheduled with Interim Deputy Medical Director MHLD and member of the MHLD team on 10/3/26. A revised completion date is expected for 31/3/26
1437	Consultant Job Planning	2024	Unsatisfactory	Medium	Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.	4.3 **Business Continuity** The EJob Plan system is a hosted platform on the cloud and is wholly reliant on an internet connection. We have not reviewed the contractual arrangement regarding disaster recovery arrangements with the supplier. We have confirmed there is no documented business continuity plan in place centrally but are unsighted whether there are arrangements in	4.3 Automate data entry processes wherever possible to reduce human error in transferring information to ESR.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2024			ESR and Job planning data is being pulled into a BI Dashboard, however, the Allocate roadmap has noted 2 phases for data transfer from Allocate Job Plan to ESR Job Plan. DS/EB to review information and arrange a meeting with Allocate to understand more with NG. Original Implementation Date has not been achieved, a revised date will be dependant on the outcome of the Allocate Roadmap.
1551	Waiting List Initiative payments – IHC Centre	2025	Unsatisfactory	High	Objective 1: There is a current WLI procedure in place that is available for all staff that align with the Amendment to the National Consultant Contract in Wales.	1. Health Board Procedure The Health Board has no Procedure detailing the planning, authorising, recording and monitoring of Waiting List Initiative (WLI) work in relation to medical and dental staff. We have noted Cardiff and Vale University Health Board have published a dedicated procedure that could be used as a template for developing one in the Health Board (Reference: Waiting List Initiative Procedure - Medical & Dental Staff UHB 515).	1. The Health Board develop, in partnership, and ratify a Waiting List Initiative Procedure to ensure Waiting List Initiative sessions are applied consistently and subject to effective scrutiny and approval across the Health Board, eliminating any inconsistent practice that may be in place with localised, undocumented procedures. The Central IHC, on behalf of the Chief Operating Officer, will lead the development of a BCUHB Waiting List Initiative Procedure.	Tehmeena Ajmal, Chief Operating Officer	31/07/2025	30/09/2026	2	* the IAST and EqIA have been approved and the draft procedure is currently being written and as noted in the 15.08.25 update, will require the procedure to be approved through the various committees, the document will then need to go through a consultation period. * A revised implementation date of 30 September 2026 has been requested and accepted due to demands of services and to also ensure correct procedures / consultation timeframes are followed
1570	Effective Governance - Cancer Services	2025	Unsatisfactory	High	Objective 3: The service is progressing and monitoring tier 2/3 clinical audits and contributing to tier 1 audits as required, with processes in place to share details of lessons learnt.	3. Clinical Audit Management advised that due to absence of Clinical Director, the service is not progressing or monitoring tier 2/3 clinical audits. A gap is identified and will therefore be reviewed by the SLT during 25/26.	3. Level 3 audits within radiotherapy are in their infancy and this is a piece of work that we are addressing following the HIW visit. We have asked an SAS Dr to support the mortality reviews with the Clinical Lead for Radiotherapy which addresses in part level 2 audits. Cancer SLT have also fed back that the Health Board needs to invest in a Chief Clinical Information Officer. Oncology is currently reliant on locum and agency medics who have no SPAs in their job plans only DCCs resulting in limited capacity. The clinical Leads will focus on creating roles with Clinical Audit responsibilities within Consultant Job Plans as we continue to recruit into vacancies on a substantive basis.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Clinical Strategy continues to be on target. Successful awayday with Senior Doctors held on the 23rd September with a similar event with nursing and AHP colleagues to be held on the 20th October

1643	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 2: Project Performance	1. **Procurement/Contract Strategy** The project is being delivered utilising the JCT Standard Building Contract Without Quantities (2016). To date, the project has experienced significant performance issues, including delays, cost uncertainty, and difficulties in managing scope changes. These issues suggest that the form of contract may not be optimally aligned with the complexity and risk profile of the project. It is acknowledged that as part of original efforts to expedite the project to meet WG expectations it was decided that a JCT Contract without quantities would offer the best solution. The UHB may wish to undertake a formal review of its choice of contract strategy, specifically the suitability of the JCT Standard Building Contract Without Quantities (2016) for complex or evolving project environments. The review could assess whether an alternative form would provide better mechanisms for collaborative risk management, cost control, and programme certainty. The findings of this (and a wider evaluation of the project delivery would help mitigate these issues on future projects.	1. Each specific project within the annual Capital Programme shall be subject to a documented delivery strategy including the project specifics, phasing/decant plan, design strategy, procurement strategy, risk management strategy and shall be used as part of the contract selection criteria. The strategy for each project shall be presented to the Director of Environment and Estates for agreement prior to inclusion in the business case. This shall be part of the business case (Commercial Case) and shall document the contract adopted and the benefits and risks. The approach undertaken with regards to Llandudno will not be progressed for future developments, with contracts awarded based on financial ceilings. *LOH: Contract executed so limited opportunity to change other than specific terms and such is unlikely to be accepted by the contractor.*	Russell Caldicott, Executive Director of Finance	31/10/2025			Due to the stage of the project there is not change to the previous update: There is little opportunity to amend LOH in this regard now other that to actively use and enforce the contract terms. Whilst there remains a narrative that the JCT contractors design shall never be used by BCU again, this should not be the case. The form of contract should reflect the specific requirements of the project and SFI's and be included in the procurement strategy at the outset.
1644	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 2: Project Performance	2. **Design delays** Prior to going out to tender the UHB engaged a design team to achieve a RIBA Stage 4 level of design to ensure that wherever possible the contractor had sufficient design information during the tender stage to provide a full cost assessment. However noting the nature of the project, it was agreed that a level of further design work would be required by the successful contractor for the project to proceed. When the Works packages were assigned to the successful bidders the UHB design team were not novated across to the appointed contractor who wished to engage their own Mechanical & Engineering (M&E) design team. It is understood however that the UHB has maintained the services of their design team to provide support during the project. The Project to date has suffered from significant delays, some of which are attributable to design considerations, of note are the following extracts from update reports (Highlight reports and Project Manager's Reports for February and March 2025), showing a timeline of design delay issues: • The WS4 (design) submission received in	2. The design strategy included in Action 1 above will be used to assess the core packages to be employer or contractor designed and include: 1. Who undertake what design packages. 2. The design stages. 3. Design transfer/novation arrangements. 4. Design warranty or professional indemnity arrangements. 5. Roles and responsibilities under the contract and for the retained team. 6. Coordination and technical submission arrangements and design variance obligations/restrictions. The criteria may vary according to the specific project. Each project shall, at the earliest opportunity, include an integrated programme for all stages to post-occupation evaluation to the design strategy. The design development, programme and risks shall be reviewed monthly and reported with escalation and mitigation. *LOH: Continue to report and review monthly with escalations and mitigations.*	Russell Caldicott, Executive Director of Finance	31/08/2025			For LOH, mitigation measures are in place. The wider implications can be picked up in the Capital Process manual.
1653	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	Medium	Objective 6: Site Progress	11. **Inspection restrictions** It was noted from conversations with the respective Clerks of Works that they did not enjoy unfettered access to the site as they were not in possession of the appropriate Construction Site Safety Certification (CSCS) to allow unaccompanied visits. As a result, visits now depend on the availability of the main contractor, with Clerk of Works personnel requiring accompaniment by main contractor employees.	11. BCUHB staff responsible for site visits shall be required to attain the appropriate CSCS accreditation commensurate with their role. This shall be deemed an essential qualification to the satisfactory execution of their duties. *LOH: Staff to be requested to obtain CSCS accreditation if their role requires it.*	Russell Caldicott, Executive Director of Finance	31/12/2025			At present, the BCUHB staff have not completed the CSCS examination process. In the meantime, mitigation arrangements are agreed with contractors to ensure free and unencumbered access to undertake site visits and inspections.

1654	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	High	Objective 6: Site Progress	12. **Commissioning Programme** The Clerks of Works noted that they had concerns over the programme of commissioning, this view is supported by the latest Project Manager's report which notes under the key risk/issues section that A detailed commissioning programme needs to be developed with input from the BCUHB / NWSSP teams. This needs to demonstrate the interdependency between both the *Main and Enabling Works programmes* . The report provides further background as to the issues and engagement to date. A formal commissioning programme was requested in Contract Administrator's Instruction (CAI) 113 issued on 13th January 2025. The first iteration that was received on 11th February did not provide sufficient detail and this was notified to the contractor, along with examples of commissioning programmes from other projects, to demonstrate the required level of detail. A revised commissioning programme is awaited. Whilst noting the above concerns as raised about commissioning it is understood that the UHB are seeking to condense the commissioning process to achieve a handover of patient areas ahead of the revised completion date. Given difficulties to	12. At the outset of the project adequate time shall be allowed for commissioning, witnessing and validation according to the specific requirements of the project including the appointment of a Commissioning Manager. *LOH: A commissioning manager has been appointed and integrated programme for agreement and adoption by stakeholders is being developed.*	Russell Caldicott, Executive Director of Finance	31/10/2025			Commissioning manager appointed and commissioning programmes are available to the project director to escalation at Board.
1672	Consultant Job Planning - Follow-up	2025	Unsatisfactory	High	Objective 4: Completed job plans reconcile to system records and session payments are correct	8. **Regular review of payments to agreed job plan commitments** *(finding in original audit report)* We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan. We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual reviewor simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan. FOLLOW-UP AUDIT REPORT FINDING: The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025	8 **REVISED ACTION IN FOLLOW-UP REPORT**: Allocate is now linked to ESR to ensure sessions agreed reflect payment. An SOP to ensure implemented will be linked to policy and will be in place by December 2025.	Clara Day, Executive Medical Director	31/12/2025			All job plans now have HB priorities included relevant evidence has been included in the return email - the dashboard now linking Allocate to ESR is now live. The internal guide has been approved via Medical Workforce Group in January 2026

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

OPEN 'LIMITED' AUDIT RECOMMENDATIONS

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Update at 24/02/2026
0491	Health and Safety - 2024	2024	Limited	Medium pre 01/10/2024	Matter Arising 3: Health & Safety Training (Operation)	3.1a : The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: "the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007".	3.1a: Further training for Executive Team to be arranged, Executive responsibility to ensure attendance	Stuart Keen, Director of Environment and Estates	01/09/2024			Quote received and the price for the delivery of the one-day HSE Certificate in Health and Safety Leadership Excellence training course at onsite in North Wales would be £9,800. This is for up to a maximum of 15 delegates and the price valid until 31 March 2026. Director of Environment and Estates notified. Further discussion needed to determine way forward.
0493	Health and Safety - 2024	2024	Limited	High	Matter Arising 5: Gap analysis (Operation)	5.1: The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board	5.1: The Review of the Gap Analysis has commenced, completion is due in April 2024	Stuart Keen, Director of Environment and Estates	30/04/2024			Cohort 2 'returns' closed in November, responses have been collated and Health and Safety Reviews scheduled and underway. Engagement of DDaT been requested to support turning an intensive manual collation task into a slicker streamlined technology solution for 2026. This work is in progress. The general findings from the gap analysis are now being fed back to the Divisions/Directorates and Areas via the Quarterly Health and Safety Performance Report and is being used by them to create improvement action plans where gaps and weaknesses have been identified.
1341	Corporate Legislative Compliance - Fire Safety	2024	Limited	Medium	Matter Arising 2: Policy for the Management of Fire Safety (Design)	2.1a The Health Board review and update its policy for the Management of Fire Safety to ensure compliance with the Welsh Health Technical Memorandum (WHTM) 05-01 'Firecode – Managing healthcare fire safety', and Welsh Assembly Government NHS Wales Fire Safety	2.1a Fire Safety Policy to be reviewed and updated to reflect the current management structure and contents in accordance with current legislation and WHTM 05-01 Firecode - Managing healthcare fire safety.	Stuart Keen, Director of Environment and Estates	20/03/2025	16/02/2026	1	Fire Safety Policy has been updated and awaiting ratification by SOHSG in February 2026.
1343	Corporate Legislative Compliance - Fire Safety	2024	Limited	High	Matter Arising 4: Fire Training (Operation)	4.1a The Health Board ensure compliance with its Fire Safety Policy and ensure full participation of its employees through a tailored training programme applicable to their individual needs. This should be constantly monitored through the Fire Safety Management Group to ensure staff compliance.	4.1a Fire Safety training to be carried out in accordance with the Fire Safety Training Delivery Plan contained within Fire Safety Policy ES04. Staff compliance levels will be reported through the Fire Safety Management Group. Data will be collected from ESR and reported accordingly. Training needs analysis will be reviewed against the new HTM o5-03 Part A.	Stuart Keen, Director of Environment and Estates	20/03/2025	01/09/2026	1	Training statistics are presented to the Fire Safety Management Group. Awaiting the publication of the WHTM05-03 Part A to review TNA.
1445	Consultant Job Planning	2024	Limited	Medium	Objective 4: Completed job plans reconcile to system records and session payments are correct	9. **Additional sessions undertaken outside of the substantive post** We found instances where some Consultants are undertaking additional sessional work for the Health Board, but these are not fully reflected/declared within their substantive job plan – This could lead to a Working Time Directive breach.	9. IHC/Divisions need to have detailed meetings with Consultants to breakdown the job plan, to identify what sessions are additional and justification of still being required to be completed.	Clara Day, Executive Medical Director; Jason Brannan, Deputy Director of People	30/09/2025			Any job plans over 12 sessions to be reviewed by the clinical leads with justification and if the requirement is still for the extra sessions what the plan is to reduce the extra PAs. IHC level dicussions occuring regards team capacity / demand / priorities meetings prior to individual job plan meetings. Anticipate this will be formally included in best practice guide when finalised
1534	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	1. Process Management	1.1: Management establish robust overarching Commissioning Assurance Framework, Policy, or relevant Standard Operating Procedure (SOP) to support the healthcare commissioning/contracting process. This should ensure that lines of escalation, roles, responsibilities, and requirements regarding the management and oversight of the quality aspect of services provided are clearly defined.	1.1: The Health Board will develop a Commissioning Assurance Framework (CAF) for the management of external healthcare contracts. This will set out the roles, responsibilities and processes and will cover not only the quality assurance of commissioned services but also the commissioning, performance management, business intelligence / analysis and other professional services that input to contract management both where the health board is commissioner and provider.	Russell Caldicott, Executive Director of Finance	30/06/2025			The draft CAF is being discussed at PFIG 24/02/26 with amended and final paper going to Health Board for approval.

1535	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	2. Contractual Obligations	2.1: Management establish controls to ensure that all commissioned providers adhere to agreed contractual agreements and assess current contract review meeting arrangements to ensure appropriate levels of oversight and engagement.	2.1: The Health Board will, as part of the Commissioning Assurance Framework (CAF) mentioned above, establish roles, responsibilities and escalations for the review of contract performance, including contract meetings.	Russell Caldicott, Executive Director of Finance	30/06/2025			The draft CAF is being discussed at PFIG 24/02/26 with amended and final paper going to Health Board for approval.
1536	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.1: Management to review contractual quality measures to ensure they are robust, effective, and appropriate.	3.1: For the 2023/2024 period, quality schedules will be included in contracts that reflect national requirements.	Russell Caldicott, Executive Director of Finance	30/06/2025			Discussions are ongoing with comissioning and qualiy teams to update quality measures and will form part of the CAF.
1537	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	3. Quality Measures	3.2: Management to ensure procedures have provision for addressing and escalating quality issues that fall outside the agreed measures.	3.2: The Health Board will, as part of the Commissioning Assurance Framework mentioned in ID 263, establish roles, responsibilities and escalations for the review of contract performance, including the dissemination of reports, the interpretation and identification of issues, the escalation process, management of remedial actions and ongoing	Russell Caldicott, Executive Director of Finance	30/06/2025			CAF has been written but is in Draft form as it hasn't, at this time, been through the appropriate governance processes for endorsement.
1538	Contracted Patient Services: Quality and Safety Arrangements - Follow-up	2025	Limited	High	4. Board Assurance	4.1: Management to review governance and reporting arrangements to ensure English NHS provider quality and performance data is subject to Health Board review and scrutiny.	4.1: The Health Board will establish a six monthly report to the Quality, Safety and Experience Committee setting out a quality assurance position for commissioned services. The ownership and authorship of this report will be clarified in the CAF.	Russell Caldicott, Executive Director of Finance	30/06/2025			Due to the retirement of the DoP&C, there has been a delay in completing item 1537 (the CAF (ID 263)). Once completed the DDoP will ensure submission of the report to QSE Committee will commence in May 2026, September 2026 and March 2027.
1558	Partnerships, Engagement and Communication	2025	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	3.1 **Staff resources** We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via	3.1 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice. Key Deliverables: 1. **Develop and implement a standard operating procedure (SOP)** that outlines: • The Health Board's expectations for engagement. • Required steps and responsibilities at each stage of the process. • Links to national guidance (e.g. WG guidance on service change). • Monitoring, assurance, and reporting requirements.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	31/01/2026	2	The BCU Co-production, Engagement and Consultation Toolkit was approved at the January Strategic Planning and Service Change Group (SPSCG) on January 16 2026. Small amends needed and the final version (for evidence) to follow.
1561	Partnerships, Engagement and Communication	2025	Limited	High	Objective 2: There is progress in delivery of the strategy elements, and evidence of improvements to date. Where these have not been delivered, there is evidence that these have been subject to discussion / change and, where appropriate, are included in future plans.	3.4 Staff resources We reviewed the evidence provided and found the following issues and limitations: • There is no SOP/policy in place outlining the engagement process and requirements. • Engagement toolkits – 2/7 published toolkits require staff to use their personal email addresses/contact details to access and use the resources. • Several documents (7/14) published on the Public Engagement Guides and Resources BetsiNet page are dated 2021/2022 – require review and updating to ensure continued relevance. • The Welsh Government Guidance on Service Change and Key Lines of Enquiry Framework document referred to is not accessible via	3.4 Consolidate and strengthen the governance and accessibility of engagement resources to ensure staff have clear, current, and secure tools to support high-quality engagement practice. Key Deliverables: 4. **Restore access to all key documents referenced**: • Upload the Welsh Government Guidance on Service Change and the Key Lines of Enquiry Framework to BetsiNet. • Ensure all links are checked quarterly for functionality.	Helen Stevens-Jones, Director of Partnerships, Engagement and Communications	30/09/2025	31/12/2025	1	In terms of the using personal emails there is a reminder above the guides on the intranet reminding people to only use BCUHB emails if they are signing up to external website or app The toolkits themselves show the date when reviewed and we state that they will be reviewed every year. All toolkits/guides are in date (previously reviewed in May 25) . How to make changes to health services: guidance for NHS organisations has also been added to the guides

1571	Effective Governance - Cancer Services	2025	Limited	High	Objective 4: Complaints, concerns, incidents and staff concerns (via Speak Up Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	4. Open / Overdue Incidents As of March 2025, the service has 195 open incidents, with 154 of these overdue.	4. The number of incidents since March has decreased significantly to 98. This is due to an agreed action of discussing and encouraging the investigating and closing of incidents in a timely manner through discussions at the daily Patient Safety Huddle, weekly e-mail reminders to incident handlers by the Patient Safety team and by further monitoring through the monthly PSQG Meeting.	Tehmeena Ajmal, Chief Operating Officer	31/10/2026			The number of incidents is continuing on a downward trajectory from the 195 open incidents / 154 overdue at the time of audit having reduced to 50 open incidents of which 34 are overdue.
1573	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Medium	Matter Arising 1: Policy (Design)	1.2 The Head of Corporate Governance will issue a guidance note to all Managers as part of the development of a Corporate Governance Hub.	1.2 Management: • Communicate operational requirements and ensure that relevant staff groups are aware of their responsibilities (e.g. role of line managers and Governance Leads in reviewing, approving, and escalating issues of concern).	Pam Wenger, Director of Corporate Governance	30/09/2025			Governance Hub populated awaiting sign off for go live - will be continuously updated.
1575	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 2: Declare System (Operation)	2.1 (b) To introduce a monitoring process for declarations in accordance with the revised Standards of Business Conduct Policy approved by the Audit Committee in May 2025.	2.1 (b) Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			The Workforce team have confirmed that the new PADR forms include reference to Declarations of Interest.
1578	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 4: Board Members declarations of interest (Operation)	**SAME AS 2.1 (b)** 4.1 (b) The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end. • Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise. • Ensures the public register of Board Member interests is maintained and kept up to date.	**SAME AS 2.1 (b)** 4.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			Confirmation that the new PADR form now includes reference to Declarations
1580	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	**SAME AS 2.1 (b)** 5.1 (b) Management: • Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	**SAME AS 2.1 (b)** 5.1 (b): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	31/10/2025			An update on declarations of interest presented to the Audit Committee in December 2025 as part of the Corporate Governance Report. • Scheduled notifications are functioning and have been evidenced • Published data is being pulled live from the system. All controls are in place as far as the system will allow. Weekly reports are produced for authorising managers. • The Declare System now has no reference to NHS England and the HB's policy is referenced. Internal Audit underway which will review the progress. Paper on the agenda for Audit Committee in April
1581	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (a) To undertake specific improvement project looking at the processes at an IHC level in relation to Declaring Gifts and Hospitality . (March 2026)	6.1 (a) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective	Pam Wenger, Director of Corporate Governance	31/03/2026			This was approved at the Audit Committee on 21 October 2025. Update covered in the report to Audit Committee; progress has been made and will be subject to Internal Audit review

1582	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	High	Matter Arising 6: Gifts, Hospitality, and Sponsored Events (Operation)	6.1 (b) To establish Governance Network working with operational leads to support the implementation of this work .	6.1 (b) Management: • Ensure all offers of hospitality and sponsored events are declared, reviewed, and approved prior to attending per policy requirements. All retrospective declarations to be escalated. • All hospitality and sponsored events to be approved by a Director / Assistant Director. • Ensure all declarations pending approval are reviewed and approved / declined. • Ensure provider details are recorded to enable effective	Pam Wenger, Director of Corporate Governance	31/03/2026			This was approved at the Audit Committee on 21 October 2025. This is being picked up as part of the Governance Improvement Plan – item on agenda to Audit Committee
1622	Falls Management - Follow up	2025	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. **Current status – Partially implemented** Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was	3.1(a) Action 2 - Training There is also a review underway by Manual Handling Manager with Service Leads to ensure those identified on ESR as requiring this training is accurate – Head of Health & Safety (29th August 2025).	Angela Wood, Executive Director of Nursing and Midwifery	29/08/2025	31/03/2026	2	Work is nearly completed in reviewing people's positional numbers but this does not mean all numbers that could be changed can be due to the impact it has on someone else with the same positional number. This exercise has highlighted a problem which starts at the recruitment stage and when inputting the JD/Positional Number on Trac, the statutory and mandatory training for the post is not checked to ensure it meets the requirements of the post. This has been discussed at the All Wales Manual Handling meeting and in some areas, to ensure the post has the correct level 1 / 2 allocated to it, the JD has been reviewed and updated with the correct positional number. This is potentially a significant piece of work for BCUHB as there are circa 3,000 JDs, and any review and update would be reliant on the availability of the Workforce Informatics Team to complete. However, the exercise to date confirms some positional changes can be made to remove level 2 training, which in turn should increase compliance. An indication of the 'shift' should be available once the positional number review has been completed.
1623	Falls Management - Follow up	2025	Limited	High	Matter Arising 3: Training (Operation and Design)	3.1(a) To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. **Current status – Partially implemented** Both the capacity of the patient handling team and training facilities continues to be an issue with regards to staff receiving patient handling training. Finding Evidence shows an increasing trend in both Patient Handling and Falls training over the last twelve months. Manual/Patient Handling remains a tier one risk on the risk register with a score of 16 (ID3893); this risk is regularly reviewed. Additionally, there is a risk for patient falls (ID5095), which includes eight actions; five of which have been completed. One of the actions includes addressing capacity within the manual handling team (ID25560), due by 30 June 2025. The Health and Safety Department have appointed two manual handling advisors in May 2025, with a start date of 1 st July 2025. 2-year formal period of development required to facilitate full and effective integration into the role. The Manual Handling team share training rooms with the wider Health and Safety team and the Resuscitation team in the East, impacting the availability of training opportunities. Whilst the use of external facilities for training was	3.1(a) Action 3 - Training Discussions ongoing regarding the upskilling of Manual Handling Champions to support the Corporate Team with local delivery of refresher training, thereby reducing the number of colleagues attending a classroom-based refresher – Head of Health, Safety & Security -October 2025.	Angela Wood, Executive Director of Nursing and Midwifery	30/10/2025	31/03/2026	1	Meeting held with the University. Costings for 250 employees to complete the course commencing April 2026 was explored. It was calculated 8 cohorts of around 30-36 people will achieve this number. Initial calculations for 16-hours x 8 cohorts would be a total of £6476.80 plus accreditation costs and an additional cost for some delivery at the Optic Centre, the satellite location in St Asaph to capture staff based at Bangor. There is £750 of funding that we may be able to access and put towards this training. Staff would need to revalidate every 5-years and we could explore a shorter course for this purpose. A request for funding has been put forward to Health Education Wales as part of the Education and Training Plan (ETP) 2027-28.

1632	Performance Management Framework and Reporting	2025	Limited	High	Objective 1: There is a governance structure with mechanisms for regular monitoring and escalation in place.	1. **Governance** Through the review of the Executive Delivery Group Minutes and reports received from two IHCs and MHLD we have not been able to confirm that Decision and Action Logs from substructure or Integrated Performance Scorecards feed into the Integrated Performance Executive Delivery Group or that performance translates down to Individual PADRs.	1. The Integrated Performance Framework to be fully implemented during quarter 2 of 2025/26. This will entail monthly meetings with the larger management structures delivering patient care. The reporting hierarchy will ensure "ward to board" assurance reporting.	Russell Caldicott, Executive Director of Finance	30/09/2025			The IPF has been revised and will be replaced by the Integrated Performance Improvement & Accountability Framework 2026-2029. At the time of reporting, this Framework is in Draft form and will be finalised and submitted to the HB for approval in March or May 2026. In the meantime, supporting tools, mechanisms, policies and governence processes are being developed and will be ready for deployment as soon as the Framework is endorsed.
1633	Performance Management Framework and Reporting	2025	Limited	High	Objective 2: There is evidence to support reported performance data and narrative.	2. **Performance** We have been unable to verify the source and rationale underpinning the identification and reporting of local performance metrics that are included in addition to the national measures. Consequently, we are unclear that the highest risk local matters are being reported for scrutiny and assurance.	2. Local performance indicators and escalations are created where a services performance is showing early signs of distress or consistently failing a target. Whilst outside of the NHS Wales performance framework it is essential to identify areas that need further scrutiny and assurance as the NHS Wales performance framework cannot cover all delivery of the NHS. The Performance Team working with the relevant Service Lead, will include the source and rationale underpinning any local metrics.	Russell Caldicott, Executive Director of Finance	30/09/2025			Within the supporing elements of the new Integrated Performance Improvement and Accountability Framework there is a detailed 'escalation and de-escaltion' policy. This policy will be used to determine the levels of ecalation and therefore the appropriate governance routes of all metrics, national or local. The policy engenders rational and objective escalation/ de-escalation of metrics through an unbiased algorithmic process.
1634	Performance Management Framework and Reporting	2025	Limited	High	Objective 3: Arrangements are in place within the operational management structure where operational leaders and Executive scrutinise and hold to account areas of poor performance, evidence this and review whether expected remedial action is implemented and improved performance to the service user.	3. **Performance Accountability** Whilst we note executive accountability meetings take place and accountability/service performance reports produced; these are not operating consistently as expected. We were unable to confirm the outcomes of performance meetings as we did not receive any minutes/evidence of specific actions set to address the required improvement in performance.	3. Finding accepted. The Health Board is in the process of setting up monthly meetings with IHCs and pan BCU patient facing services. Initial meetings have been held in quarter 1 with monthly meeting to be diarised during quarter 2 to run monthly from September onwards.	Russell Caldicott, Executive Director of Finance	30/09/2025			The new Integrated Performance Improvement and Accountability Framework for 2026-2029 features a suite of supporting elements, of which regular Integrated Performance Improvement and Accountability Reviews are a critical component. These Reviews are to be held at various levels of the organisational hierarchy starting with high level executive reviews and as the implementation of the IPIAF progresses, will work down through the organisational hierarchy eventually being incorporated within every employee's Personal Appraisal Development Reviews (PADRs). The supporting documentation for the IPIAF includes Terms of Reference and will include a timetable of all the IPIA Reviews for the fiscal year.
1658	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	High	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	3. **Limited Plan Testing** While some exercises have been conducted, most BCPs and incident plans have not been tested. Testing is not yet consistent across all departments. Women's Services exercises are delayed, and exercises for Emergency Departments are still in planning.	1) To draft an options appraisal on how we can best achieve the above. 2)To receive Executive sponsor sign off on the options appraisal, and take though the governance route of CCAG, Executive Committee and PPHP if required. 3)To then action and implement the agreed recommendation/option following governance reviews.	Jane Moore, Executive Director of Public Health	31/12/2025	31/03/2026	1	SBAR Optionals appraisal paper was circulated to CCAG colleagues December 2025 and then again following the CCAG meeting January 22nd 2026 for comments. Chair of the CCAG JM stated paper to now go to EC, waiting for confirmation on the EC agenda for decision. Once decision made, a full governance work programme, with measuring tools will be developed.
1660	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	Medium	Objective 2: Adequate and tested plans in place for the Health Board to deal with emergencies and business continuity, that are supported by risk assessments and with appropriate polices / guidance / training for staff responsible for these plans.	5. **Outdated Policies and Procedures.** Core EPRR policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.	All outstanding EPRR policies, templates, plans, policies and SOPs are agenda for approval/sign off at the next CCAG 30th September 2025.	Jane Moore, Executive Director of Public Health	31/12/2025	31/03/2026	1	Work is progressing around this, in line with the Health Board policy management process.
1679	Digital Benefits and Change	2025	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.2 **Benefits Reporting** Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital	2.2 Agree benefits reporting structure with the Executive Team to demonstrate the value of projects across various BCUHB governance groups outside of the DDaT Team.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026			On the 26th November 2025 the Executive Committee agreed that DDaT would provide quarterly updates to the PPHP committee to demonstrate the value of projects. The first of these reports was due to be considered in March, but due to a scheduling error this will now be May 2026.

1680	Digital Benefits and Change	2025	Limited	High	Objective 3: Benefits are tracked and the structure ensures that these are achieved, with actions taken if they do not accrue	2.3 **Benefits Reporting** Currently there is no structured process for tracking and reporting of benefits outside of individual projects and programmes. We also note that there is some reporting of benefits as part of the reporting on digital programmes to PFIG, however these are at a high / general level without detail, and as such DDaT is not fully demonstrating the value gained by digital projects.	2.3 Review the Benefits Framework to include updated reporting and escalation routes.	Dylan Roberts, Chief Digital and Information Officer	31/03/2026			SBAR to DPDG 18/11/25 recommending a revision to Section 11 - Benefits Governance of the Benefits Management Framework, describing the Forums and Reporting structures that should be established at Owner, Project, Programme and Portfolio Level. Recommendation approved and Benefits Framework updated to reflect. To improve the reporting and tracking elements within the Benefits Framework revisions to Section 7.4 Realise will be presented to the next DPDG for approval (17/03/26).
1702	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	1. **Governance** We reviewed the governance arrangements in place and noted the following limitations: • The Health Board does not have an overarching policy or written control documents in place to support operational processes and ensure regulatory engagement, implementation, compliance, and escalation are managed consistently. • The Health Board does not retain a central register of regulatory reporting routes. Due to low engagement, we were only able to establish the key Health Board contacts for ten of the twenty-two known regulators • Areas / services have developed processes to manage regulatory reports and engagement independently – there is no consistent escalation	• An overarching policy and associated written control document will be approved to support operational processes and ensure regulatory engagement, implementation and compliance, ensuring escalation is managed consistently. • A central register of regulators as well as Executive Team Member lead, and regulatory reporting routes • The Corporate Governance Directorate to work with areas/services to develop processes to manage regulatory reports and engagement independently.	Pam Wenger, Director of Corporate Governance	31/03/2027			A Relationship Management Matrix is currently being populated across the Health Board, which will capture a list of all our regulators, statutory and professional bodies, our current relationship with them, processes associated with their publications, and the monitoring and reporting arrangements. The deadline for submissions into this work is 27/02/2026. Following this the Matrix will be reviewed to identify the key risk areas, and the Statutory Compliance Team will work with leads to strengthen the current governance arrangements with these organisations.
1703	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	2.1 **Regulatory Assurance Group (RAG)** The Health Board Regulatory Assurance Group is not fulfilling its remit per the Group terms of reference as "the single point of focus for healthcare related regulation oversight and assurance activity across the Health Board" – the Group's oversight is restricted to a limited number of regulators / regulatory reports (HIW, CIW, PSOW, and HSE). Note that the regulatory reports reviewed by RAG are subject to robust oversight and scrutiny by the Group.	The Health Board has existing arrangements in place and the spirit in which the Regulatory Assurance Group was established was to focus on the Regulators as defined in the Duty of Quality. Therefore to avoid any confusion, it is recommended that the Terms of Reference are reviewed. • Review the Terms of Reference to reflect the role of the Group in line with the Quality Regulation Policy	Pam Wenger, Director of Corporate Governance	31/03/2026			Work has commenced in mid-January on compiling a register of all regulators, statutory and professional bodies across the Health Board. Once completed, this Register will be reviewed to identify areas where the Health Board needs to improve its relationship with the regulator/body, and the way requests from these bodies are progressed, monitored and reported within the Health Board. The information within the Register will inform the reporting to the new Regulation and Governance Executive Delivery Group. Discussions are ongoing between the Director of Corporate Governance and Executive Team members around this Group to ensure that the correct cycle of business is put in place, and the correct membership to ensure decision-making.
1704	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	2.2 **Regulatory Assurance Group (RAG)** The Health Board Regulatory Assurance Group is not fulfilling its remit per the Group terms of reference as "the single point of focus for healthcare related regulation oversight and assurance activity across the Health Board" – the Group's oversight is restricted to a limited number of regulators / regulatory reports (HIW, CIW, PSOW, and HSE). Note that the regulatory reports reviewed by RAG are subject to robust oversight and scrutiny by the Group.	The Health Board has existing arrangements in place and the spirit in which the Regulatory Assurance Group was established was to focus on the Regulators as defined in the Duty of Quality. Therefore to avoid any confusion, it is recommended that the Terms of Reference are reviewed. • To develop a corporate procedure and reporting routes for the monitoring of regulatory reports at a corporate level; eg, MHRA, HSE and other regulators	Pam Wenger, Director of Corporate Governance	31/03/2026			The Governance and Compliance Group will have a wider regulatory focus not just corporate, and work is still taking place to identify the correct membership, and the cycle of business, and the scoping of the agenda to take place following further discussions with Executive Team Members.

1705	Learning – Regulatory Reporting	2025	Limited	High	Objective 1: Robust processes and governance arrangements are in place to ensure that learning from regulatory bodies is captured, managed, and shared appropriately, at corporate and operational level.	3. **Operational Processes** For the ten regulators reviewed, we confirmed that processes have been established locally to manage and implement required improvement actions to ensure compliance with regulatory requirements. However, we noted the following limitations: • Regulatory reports are not managed consistently across the Health Board - processes, reporting, and escalation arrangements vary by regulator, area, and / or service. • There are no formal processes or requirements to support the management, sharing, implementation, and tracking of wider learning from regulatory reports. • We were unable to verify the robustness and consistency of oversight and escalation arrangements from the evidence provided and could not confirm that regulatory assurance is consistently provided to the Board.	• A consistent process will be implemented to manage regulatory reports to include reporting and escalation arrangements by regulator to ensure robustness and consistency of oversight and escalation arrangements • High level reporting against regulatory reports will be included in the statutory compliance report to Audit Committee as well as individual oversight by committees as per the Scheme of Delegation.	Pam Wenger, Director of Corporate Governance	31/03/2027			In November 2025, the Executive Committee has agreed to the creation of a Governance and Compliance Group, and work is ongoing to develop the draft terms of reference and membership of that Group. It is proposed that regulatory compliance will be reported into that Group, and the processes around that are being developed. This group will have a wider regulatory focus not just corporate, and work is still taking place to identify the correct membership, and the cycle of business, and the scoping of the agenda to take place following further discussions with Executive Team Members.
1706	Learning – Regulatory Reporting	2025	Limited	High	Objective 2: There is evidence to demonstrate that opportunities for learning from regulatory reports are implemented, and outcomes are reviewed to ensure effectiveness and limit future occurrence.	4. **Learning (Process)** There is no policy or other formal written control documents in place outlining the requirements regarding the extraction, management, sharing and tracking of learning from regulatory reports. Regulatory reports and notices do not typically specify wider learning - they provide defined improvement actions needed to meet regulatory standards. Despite this, examples of wider learning being extracted and shared were provided for review. However, we cannot be assured that this is consistent for all regulatory reports, or that all opportunities for learning are captured.	The Executive Committee has established a Learning and Discovery Group which will focus on the learning from external reports and inquiries, this will ensure that learning is extracted implemented in the Health Board Agreed Action: • Develop Standard Operating Procedure outlining how learning is to be extracted, shared, tracked, and implemented.	Pam Wenger, Director of Corporate Governance	31/03/2026			The draft 'Procedure for Referral to the Discovery and Learning Steering Group' has been produced, and shared with that Group's Chair, the Executive Director of Nursing and Midwifery, who has reviewed the Procedure and is happy with the content. It will now be submitted to the Executive Quality Delivery Group for approval. This meeting is due to take place in February 2026.
1707	Learning – Regulatory Reporting	2025	Limited	High	Objective 2: There is evidence to demonstrate that opportunities for learning from regulatory reports are implemented, and outcomes are reviewed to ensure effectiveness and limit future occurrence.	5. **Implementation and tracking of learning** The Health Board does not have a formal system to track the implementation and impact / outcome of shared learning from regulatory reports. For the examples provided, we were able to confirm that the relevant learning had been shared, however could not confirm in all cases that required actions were subsequently implemented / actioned.	The finding in this recommendation is linked to the key finding in 1 and this is already included in the work programme as described in the IMTP. The action will therefore be aligned to the Board approval of the IMTP. Agreed Action: • Develop and implement a formal system to track the implementation and impact of shared learning from regulatory reports across the Health Board.	Pam Wenger, Director of Corporate Governance	31/03/2027			The Relationship Management Matrix around regulators, statutory and professional bodies includes a request for information around how current learning from regulatory reports is being captured, disseminated the actioned. The work of the Governance and Compliance Group will include the processes around the dissemination of learning from regulatory reports.
1749	Complaints management	2025	Limited	High	Objective 2: Complaints have followed the relevant process and are supported by documentation and evidence i.e. investigation reports, learning.	3. **Learning and Improvement Plan action plans – Compliance with Policy** No supporting evidence was noted in our review of DATIX to confirm the closure of actions, despite these being recorded as complete and closed. We also confirmed that no routine audits are being undertaken by the Complaints Team to verify the closure of actions are supported – This is a breach of PTR 01 Integrated Concerns Policy – paragraph 16.7.	PTR 01 Integrated Concerns Policy – paragraph 16.7 has been changed to ensure clearer wording that the learning from complaints must be evidenced and recorded by services. In addition to this the health board is in the final stages of developing a dedicated learning repository to support evidence gathering on agreed learning actions identified in the complaints process.	Angela Wood, Executive Director of Nursing and Midwifery	01/08/2026			16.7 has been changed and submitted for approval however once the LTP regulations are released by Welsh Government the PTR 01 Policy will require amendments to mirror these changes. A specific Patient Experience data modeling has been produced which now has the ability to look at free text contained witin Civica feedback to capture true patient experience beyond quantitive measures but now includes unrestricted narrative which will drive improvements in patient experience.

1751	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	**1. Procurement training** Welsh Health Circular (WHC/2024/013) Governance on interim appointments to Executive and Senior Positions requires "Procurement training is mandatory and must be in place for all Executive Directors and all staff involved in procurement". We obtained details of officers who have attended procurement training from the Finance Directorate who maintain the list of attendees. We noted recently appointed Executive Directors are yet to receive their mandatory procurement training. We reviewed a sample of officers delegated to approve requisitions against the training records	• Develop and maintain a register of all officers required to complete procurement training exploring the use of ESR to record compliance (Director of Workforce and OD); and • Schedule mandatory sessions for Executive Directors and delegated officers (Director of Workforce and OD)	Debbie Eyitayo, Executive Director of People Services and Organisational Development	31/12/2025			All Executive Team members undertook training around procurement with the NWSSP Head of Operational Procurement and National Sourcing on 03/12/2025. Procurement Training is now a core module within ESR aligned to Executive position numbers. Additional sessions are required to ensure all execs are compliant
1752	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	2. **Accountability Agreements** Accountability Agreements detail explicitly the expectations of Budget Holders, including: 'I will adhere to the Health Boards approved Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, specifically in regards to recruitment and commissioning of goods and services; I will attend a mandatory session for Procurement of goods and services (dates to be shared) hosted by Procurement Shared Services for Wales, it is my responsibility to ensure I attend one of the planned sessions once dates are confirmed. Ensure as far as I am able that all non-pay expenditure complies with the requirements of the Standing Financial Instructions including the requirement for an official purchase order to be raised in advance of incurring the expenditure'. The review of data obtained from the Finance Directorate concerning the status of Tier 1 (Chief Executive) and Tier 2 (Executive/Corporate Directors) Accountability Agreements, as of 2 October 2025, for the 2025/26 financial year notes nine(64%) recorded as not replied to the request to sign the agreement; one (7%) recorded as refusing to sign the agreement; and four (29%) signing the agreement. We are aware that escalation meetings have taken place however	• Ensure all Tier 1–2 officers sign Accountability Agreements for 2025/26. • Escalate non-compliance to Audit Committee with reasons for refusal	Russell Caldicott, Executive Director of Finance	31/12/2025			Out of the Tier 1 and Tier 2 officers, one tier officer has not responded and one officer has not signed but there is valid reason due to long term absence. 413 out of 433 accountability agreements were signed across the Health Board. Out of the 20 not signed, 8 had a valid reason for not signing (for example, due to long term absence from work, etc.) and 12 provided no response.
1754	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	4. **Direct Call Off (DCO) framework use** The review of DCO evidence does not demonstrate the Health Board has consistently achieved best value in the selection of suppliers for DCO awards where officers are routinely undertaking DCO with suppliers, without engaging NWSSP Procurement Services first to ensure best route to the market. The NHS Wales Procurement Manual states "Depending upon the requirement and value of the opportunity, 'direct call off' may not offer the best value solution overall. The lead and Procurement Lead will consider this at the planning stage. Suppliers should be invited to bid via the Procurement Service appointed e-procurement solution"	• Procurement training to ensure the reduction in Direct Call Off by engaging NWSSP Procurement Services at planning stage. • Monitor and report DCO usage quarterly (via procurement report)	Russell Caldicott, Executive Director of Finance	31/03/2026			Procurement training sessions are ongoing to ensure all Directors and budget holders have attended.

1755	Contract management and procurement review – Corporate Directors	2025	Limited	High	Objective 1: To ensure the requirements stipulated within the Health Board's Standing Financial Instructions are complied with at all times.	5. **Compliance with the Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD)** There are detailed expected controls in the Standing Financial Instructions, relating to procurement, that have been refreshed to align with the Procurement Act 2023 and Health Services (Provider Selection Regime) (Wales) Regulations 2025). A review of the procurement data in our sample has identified the following SFIs that show inconsistent compliance: • Procurement advice is sought from Procurement Services at the outset (SFI 11.3.6). • Effective planning of procurement exercises with Procurement Services was soon as possible to ensure compliance with minimum competition thresholds (SFI 11.9.2). • For 'Goods and Non-Health Services Only', advice from Procurement Services is sought for all requirements in excess of £5,000 (excluding VAT) (SFI 11.11.2). • No Purchase Order, No Pay where retrospective requests have been made to facilitate payment of an invoice (SFI 11.19). We found instances where contracts between the	• Deliver update sessions on revised SFIs and SoRD to all Executive and Corporate Directors. • Notify NWSSP Procurement Services of all delegated officers authorised to sign contracts. • Ensure all contracts are signed by authorised officers before commencement.	Russell Caldicott, Executive Director of Finance; Pam Wenger, Director of Corporate Governance	31/03/2026			Procurement training sessions are ongoing to ensure all Directors and budget holders have attended. NWSSP Procurement Services comply with the Schemes of Delegation for the Health Board
1759	Value and Sustainability – Delivering Quality Improvements	2026	Limited	High	Objective 1: Robust process and governance arrangements are in place to manage and support implementation / delivery of the Value and Sustainability workstreams. All approved initiatives adhere to the principles of Value and Sustainability with a clear focus on improving quality and outcomes.	1. **Value and Sustainability** The Health Board Guidance for Savings 2025-26 provides comprehensive support for the finance and costs aspect of savings applications and reporting, however, does not reference non-financial, wider value and sustainability factors. Furthermore, there is no provision in the Savings Submission Document (SSD) to record or evaluate the impact of implementation on non-financial measures such as quality and outcomes. Whilst we recognise there is no formal national policy/guide outlining specific requirements regarding the inclusion and consideration of non-financial factors in the development, implementation, and reporting of Value and Sustainability saving plans, the principle that Value and Sustainability is broader than financial cost savings is outlined in the Health Board Integrated Medium-Term Plan 2025-28 2E.1 that states 'Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement.' We confirmed that work has commenced on developing the monitoring and reporting of Value and Sustainability schemes to provide oversight of	1.0 Combine Clinical Variation & Value-Based Health Care into a merged workstream which will act as the primary driver for quality-led clinical improvement initiatives within the V&S framework. This newly formed workstream will be operational in Q4 (with priority areas of focus agreed by end Feb-26). 1.1 A comprehensive 'Value' benefits framework is already in development based on the HFMA value definition: Outcomes + Experience / Cost (developed in conjunction with BCU's Benefits Lead). This will provide a more holistic (quality) view of programme delivery, over and above savings. The final version will be presented for ratification at Programme Board Feb-26. Any future initiatives will be prioritised against this wider framework. 1.2 Work has commenced with the PMO to refine and utilise the Portal as the vehicle to capture and report benefits realisation for 'non-transactional' value schemes that deliver against multiple metrics of value. This will sit alongside the existing national monitoring return, which focuses exclusively on cost savings. This will be completed by end of March-26 and be operational for delivery against our agreed programme of work for 26-27 1.3 Programme reporting (particularly highlight reports and reports into IPEDG and PFIG) will cover the wider set of value metrics included in the benefits framework. This will be in place for end of March-26 and will provide greater assurance around the quality outcomes of the V&S programme for 26-27	Russell Caldicott, Executive Director of Finance	31/03/2026			1.0 Clinical Variation and Value-Based Heath Care workstreams combined, inaugural meeting to be scheduled late Mar-26. Priority areas confirmed via national V&S Board. 1.1 Benefits Framework developed, to be submitted at re-scheduled Programme Board 16/03 1.2 Discussions commenced with PMO team, however timeline for delivery will require re-scheduling 1.3 Not due till Apr-26

1760	Value and Sustainability – Delivering Quality Improvements	2026	Limited	High	Objective 2: There is evidence to demonstrate that approved initiatives are progressing and delivering the purported savings and quality improvements – this will include the implementation and delivery of Value and Sustainability initiatives identified internally, by other Health Boards, or through the national Value and Sustainability Board.	2. **Saving Submission Documents** We reviewed the approved Saving Submission Documents (SSDs) for each of the 22 saving schemes in our review sample and noted that the quality and comprehensiveness of Supporting Financial Analysis was not consistent across schemes. For 6/22 schemes reviewed we were unable to confirm how the savings had been determined or whether costings were robust from the information / data supporting the SSDs.	2.1 Reinstate the submission deadline to ensure that all SSDs are submitted with sufficient time to fully evaluate the supporting documentation. 2.2 Review of the narrative in the 'BCU Guidance for Savings' to allow planned savings information to be contained within a specialist system (e.g., in this case the meds management system), with the output from the system being sufficient to demonstrate the estimate provided for the saving value is reasonable. (Avoiding duplication of systems and ensuring one source of information).	Russell Caldicott, Executive Director of Finance	31/03/2026			The guidance is in the process of finalisation.
1761	Value and Sustainability – Delivering Quality Improvements	2026	Limited	High	Objective 2: There is evidence to demonstrate that approved initiatives are progressing and delivering the purported savings and quality improvements – this will include the implementation and delivery of Value and Sustainability initiatives identified internally, by other Health Boards, or through the national Value and Sustainability Board.	3. **Actual Savings Reconciliation** We requested evidence of actual savings delivery at Month 6 for each of the 22 schemes reviewed – this was provided for 17/22 schemes. We reviewed the supporting documentation and reconciled the working documents to the tracker. We found the following limitations: <u>Cancer Services</u> • The reported savings for one (of two) Cancer Services Medicines Management scheme in our review sample was less than the actual saving achieved per the backing documentation. We were advised that the reported figure was an adjustment for a prior over-reporting of a different Cancer Services Medicines Management scheme - the over reporting was not corrected against the relevant scheme as the accepted practice is that negative values should not be reported on the tracker. • Cancer Services has six Medicines Management saving schemes. We confirmed that the aggregate reported savings (for the six schemes) reconciled to the total savings per the backing document. However, due to the adjustments the reported savings on the tracker was inaccurate for four of the six schemes. Mental Health and Learning Disabilities • Scheme MHLD25004-01 (Reduction in Out of	3.1 The guidance on how to adjust future savings values to correct estimates, where actual information is not available at the point of submission is not clear. Advice will be taken from WG, as potentially limiting over estimates to one scheme may result in over reporting for some months. When guidance is received, we will strengthen the internal guidance to incorporate the WG views and advice. 3.2 WG have confirmed the Mental Health and Learning Disabilities scheme has been recorded correctly and in accordance with their requirements. However, it is recognised that neither the WG or BCU internal guidance specifically document the process, and the internal guidance will be strengthened to ensure this scenario is covered.	Russell Caldicott, Executive Director of Finance	31/03/2026			Advice has been recevied from WG and the guidance is in the process of finalisation.
1762	Estate Management – Estates and Facilities Alerts	2026	Limited	High	Objective 1: Governance & Oversight - to review the governance arrangements and internal processes for receiving, reviewing, and disseminating Estates and Facilities (E&F) Alerts within the Health Board.	1. **Governance and Oversight of Estates and Facilities Alerts** Operational Estates Alerts are received by the Head of Estates and Senior Estates Officer – Policy and Technical Compliance, however there is no evidence of consistent oversight or assurance that all alerts are reviewed and acted upon. Although a central register exists to record (E&F) Alerts, actions taken in response are not routinely updated or tracked to completion. There is currently no overarching governance group within Estates responsible for reviewing all safety alerts and ensuring compliance. There is no Standard Operating Procedure (SOP) for the management of (E&F) Alerts.	• Interim measure has been implemented with a SOP to include a single point of access to all alerts so all parties can access the information. This includes a monitoring spreadsheet. • Review the full directorate reporting structure and how that relates to the other groups within the organisation to ensure clarity and accountability. This is driven by other factors and will include additional roles to support responses such as this. • Define a directorate governance structure to encompass all statutory reporting and the management of Alerts and record such in a SOP. • Finalise a reporting route to ensure organisational assurance and the potential for an annual Estates compliance report.	Stuart Keen, Director of Environment and Estates	Interim measure: 28/02/2026 31/07/2026 for the finalisation of the structure given the wider organisation restructure and approval of governance.			SOP developed for the management of Estates and Facilities Alerts and report on progress presented at the Operational Estates Health and Safety meeting. SOP used in the High Voltage alerts that re received by the Health Board on 16th Feb 2026.
1763	Estate Management – Estates and Facilities Alerts	2026	Limited	High	Objective 2: Monitoring and Reporting – to assess the adequacy, timeliness, and evidence of actions taken in response to E&F alerts, including risk assessments, implementation of required measures, and monitoring of compliance or closure.	2. **Monitoring implementation** A central register exists to record (E&F) Alerts, but follow-up actions are not consistently updated. A review of eight (25%) recent alerts showed that three out of the eight (37.5%) had no evidence of implementation, suggesting incomplete follow-up.	• The SOP will include the development of a tracker to include information such as: Description, Risk Rating, Owner, Target Implementation Date, Implementation Evidence, Link to Corporate Risk Register, etc. • As an interim measure, a tracker will be developed to collate the current Alerts and form the basis of a transition mitigation pending the SOP.	Stuart Keen, Director of Environment and Estates	Interim tracker – 28/02/2026 Full tracker – 31/07/2026			As part of the SOP the tracker has been developed and used as part of the High Voltage Safety Alerts that were issued 16th Feb 2026

1764	On-call arrangements	2026	Limited	High	Objective 1: Review the on-call arrangements across the Health Board, and consider whether rotas include the relevant mix/seniority of staff, are fair, and sustainable.	1. **On-call rota composition, fairness and sustainability** Although a draft on-call policy is now in place and provides improved clarity on the intended structure and seniority of Gold, Silver and Bronze rotas, the policy remains unapproved and not fully embedded. As a result, rota composition continues to rely on local practice. Staff feedback indicates ongoing perceptions of inequity in rota participation, lack of transparency regarding inclusion/exclusion of eligible staff, and concerns about the sustainability of rotas due to workload pressures, turnover and reliance on goodwill. These issues were also highlighted in the previous audit and remain partially unresolved.	1. Management will work with the Foundations of the Future workstreams and Workforce & OD to develop, consult on, and ratify an On-Call Rota Policy that establishes a fair, transparent and sustainable on-call model across Gold, Silver and Bronze rotas. The policy will clearly define the rota structure, eligibility criteria, and expected seniority, and will set out roles and responsibilities for all participants, including escalation and decision-making arrangements. The policy will explicitly state that all substantive and/or acting post-holders at Band 8a and above are expected to participate in the on-call rota unless exceptional circumstances apply, with the criteria and approval process for exemptions clearly documented to ensure consistency and transparency. Rota governance arrangements will be included, covering accountability for roster composition, maintenance, monitoring of participation, and periodic review to support sustainability and address workload pressures and turnover risks. Ownership and ongoing responsibility for the policy will sit with Operations, including ensuring the policy is embedded into business-as-usual processes and communicated to relevant staff. Until the Foundations of the Future arrangements are implemented and the policy is formally ratified, the Health Board accepts the residual risk associated with the absence of an approved and fully embedded on-call policy.	Tehmeena Ajmal, Chief Operating Officer	31/12/2026			*Report received after requests for updates submitted*
1765	On-call arrangements	2026	Limited	High	Objective 2: Review whether staff are taking, or are able to take, compensatory rest periods following on-call duty, and how these are recorded/monitored.	2. **Compensatory rest arrangements** The audit found that relevant workforce policies covering compensatory rest are in place and have been updated, and management communications have reinforced expectations. However, staff feedback indicates that many on-call staff remain unable to take compensatory rest in practice due to workload and operational pressures. Where rest is taken, it is often informal and inconsistently recorded. There is no standardised process for recording, monitoring or reviewing compensatory rest following on-call duty, a weakness also identified in the previous audit.	2. Reiteration for the need to plan compensatory rest into staff diaries and work plans will be included within the EPRR/on call Preparing for Emergencies training undertaken by the EPRR Lead, which will be mandatory for all staff on the on-call rotas.	Tehmeena Ajmal, Chief Operating Officer	31/12/2026			*Report received after requests for updates submitted*
1767	On-call arrangements	2026	Limited	Medium	Objective 4: Confirm that appropriate training, guidance, and support are available for staff	3. **Training, guidance and support for on-call staff** The audit found clear improvement since the previous review, with training specifically for major incidents available and supported by a central training matrix. Monthly Management On-Call Drop-In Sessions also aid learning. However, staff feedback indicates that awareness and experience of training, guidance and practical support is not yet consistent across all services. Access to site-specific guidance and formalised debriefing remains variable, and while training completion is monitored, there is limited evidence of routine review of ongoing competency and learning needs.	3. EPRR and on call training to be mandated for all staff on Bronze Silver and Gold rota – and to be updated every 3 years Where staff repeatedly fail to book or attend training, this is to be escalated through line management and, where appropriate, the relevant executive for resolution.	Tehmeena Ajmal, Chief Operating Officer	31/03/2027			*Report received after requests for updates submitted*

1768	On-call arrangements	2026	Limited	High	Objective 4: Confirm that appropriate training, guidance, and support are available for staff	4. As a Category 1 Responder, the Health Board supports Gold on call Executives to attend the pan-Wales 'Exercise Wales Gold' training to help maintain emergency response competencies, although attendance has only been tracked since 2025 and training places are limited. Currently only four Executives have attended the training. In the absence of all Executives having attended this training, the Health Board cannot demonstrate it has appropriate arrangements in place to evidence that staff have received the necessary training to respond effectively to emergencies, in line with the expectations of the Civil Contingencies Act and its statutory guidance.	4. Attendance at the Pan-Wales Gold training for all Gold on call to be mandated– and to be updated every 3 years Dates for 2026 Wales Gold Training circulated to all Gold on call (6 spaces available in 2026) – completed Head of EPRR to continue to seek additional training dates for the training programme with the national team.	Tehmeena Ajmal, Chief Operating Officer	31/03/2028			*Report received after requests for updates submitted*
1769	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	Medium	Objective 1: To review the governance arrangements in place for managing NICE guidance across the Health Board in line with WG requirements, including implementation of Technology Appraisals.	1. **Assurance to the Health Board** The information provided to the Committee and Health Board through the Integrated Quality Reports is more limited than the detail shared with SCEG. This restricts the level of assurance available at Board level. There is an opportunity to strengthen reporting by placing greater emphasis on NICE guidelines, particularly those marked as partially achieved or not achieved, to ensure appropriate oversight and improvement monitoring.	A more detailed report will be provided for QSE to be included within the Integrated Quality Report. Strategic Clinical Effectiveness Group has already started to seek greater assurance on non-complaint and partially compliant guidance, and this will be reflected in reporting. The Teams first updated report will be provided for the bi monthly report, February to March into QSE in May 2026.	Clara Day, Executive Medical Director	27/04/2026			*Report received after requests for updates submitted*
1770	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	High	Objective 1: To review the governance arrangements in place for managing NICE guidance across the Health Board in line with WG requirements, including implementation of Technology Appraisals.	2. **New Treatment Fund / IPFR reporting** The New Treatment Fund and Individual Patient Funding Requests (IPFR) paper has not been presented to the Executive Committee since February 2025. We note that reports were requested, prepared, and submitted to the committee for inclusion on the agenda.	Reports had been prepared throughout the year for Executive Committee but not presented. Pharmacy has now moved into the Office of the Medical Director who will ensure a regular reporting cycle. A report was presented to executive committee in Jan 2026. It has been agreed by the EMD that in future this will report via SCEG every 3 months with a corresponding update then to executive committee. It will focus not only on cost allocation but also whether we are meeting our duties to provide	Clara Day, Executive Medical Director	17/03/2026			*Report received after requests for updates submitted*
1771	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	Medium	Objective 2: To determine how compliance with NICE guidance (including Technology Appraisals) is assessed and monitored, through tools such as clinical audits, patient surveys, and the NICE compliance database, with required reporting to the Welsh Government	3. **Service compliance assessments** An override function exists within the AMaT system, enabling either the Clinical Lead or the Clinical Effectiveness Team (CET) to bypass the completion of compliance reviews. Whilst it is acceptable for CET to exercise this functionality with appropriate justification, the absence of notification or rationale from the Clinical Lead when applying an override could result in ambiguity and weaken governance controls.	The problem with AMaT has previously been highlighted with the Welsh NICE Health Network (WNHN) by the health board. We have been informed that this will need to be an All Wales/England change, that all health boards will need to agree. Our latest update from AMaT 27/01/26, is as follows, AMaT confirmed that currently users can still override, though they are working on a change in Q1/2 that will prevent that in the future. The Clinical Effectiveness team will continue to keep on the agenda with them. We will develop a standardised message to send out to services explaining who can override and in which circumstances to strengthen controls.	Clara Day, Executive Medical Director	27/03/2026			*Report received after requests for updates submitted*

1772	National Institute for Health and Care Excellence (NICE) guidance compliance	2026	Limited	High	Objective 2: To determine how compliance with NICE guidance (including Technology Appraisals) is assessed and monitored, through tools such as clinical audits, patient surveys, and the NICE compliance database, with required reporting to the Welsh Government	4. **NICE Baseline Assessment** Tools It was identified that NICE Baseline Assessment Tools (BATs) are not consistently completed following the recording of compliance assessments that are 'partially achieved improvement needed' or 'not achieved' via the AMaT system. We have been unable to obtain assurance that SMART action plans had been developed or that any associated follow-up actions were being effectively monitored and implemented.	Targeted training has already commenced by Clinical Effectiveness Team for BAT with clinical services and will continue until embedded (NICE guidance (NGs) and Clinical guidance (CGs) are the only ones requiring BATs). The Clinical Effectiveness team have recently trialled doing joint service reviews around the table for complex multiservice guidance. A recent success with the Mental Health Team and other related services. This will continue for complex guidance until BAT well embedded. Each time this is done services will be asked to have a BAT lead present, for future leadership within services completion. Teams training dates will be offered to services for basic BAT training with emphasis on appropriate action plans. The Clinical Effectiveness team will do quarterly audit checks on AMaT for compliance with BATs, appropriate action plans, and appropriate risk descriptions. The above will be monitored via SCEG reports for assurance.	Clara Day, Executive Medical Director	01/12/2026			*Report received after requests for updates submitted*

OPEN EXTERNAL AUDIT RECOMMENDATIONS

ID	Report Title	Year	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Update at 24/02/2026
0394	Structured Assessment 2022	2023	Recommendation 12: Improve performance and financial oversight for digital and estates	R12b: There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation.	R12b: Although addressing deficiencies and risks are the priority proof of value, work in small affordable pockets are progressing and demonstrating the benefits that can be delivered if scaled.	Dylan Roberts, Chief Digital and Information Officer	31/12/2023	31/03/2026	2	Evidence is available via Committee Papers and the Health Board's Annual Plan. Supported recommendation for closure. Estates: There is an Estate Strategy from 2023 and whilist a recognition that it needs to be updated, this is not viable until there are accepted clinical service plans so that the strategy follows the service. Capital and Estates funding is reported monthly with monitoring and mitigation implemented. There is a risk based approach to prioritisation of capital and estates spends. Estates spend is reported through financial workstreams. The implementation date of 03/2026 will need extending.
1453	Structured Assessment 2024	2024	Recommendation 2	R2. In the context of ongoing work in relation to the Foundations of the Future programme and strengthening its operational governance the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role.	R2: Currently there is no accountability or responsibility for the Senior Leadership Team in terms of operational governance, it is a mechanism by which the Members of the Executive Team can engage to support the delivery of the Health Board plans. As part of the Foundations for the Future Programme, clarity on roles and responsibilities for groups will be confirmed alongside the role of the Senior Leadership Team and the Operational Leadership Team. Key actions include: **• Review of the operational governance arrangements including the role of the Senior Leadership Team**	Pam Wenger, Director of Corporate Governance	31/07/2025	28/02/2026	1	Update the Operational Governance Framework is being scoped out with a paper programmed for 18 March 2026 for Exec Cttee to consider. This will contain draft Terms of Reference for SLT Teams
1456	Structured Assessment 2024	2024	Recommendation 5	R5. The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board.	R5: The Health Board is considering the most appropriate way to engage the wider Board in terms of visiting services. Individual Board Members visit sites on a regular basis. Key actions include: **• Agree how the Board can engage with services, which will include plans in terms of service reviews;** **• Establish a reporting mechanism to the Board in terms of service visits**	Pam Wenger, Director of Corporate Governance	30/06/2025			Update provided to the Board in the Corporate Governance Report March. Programme being rolled out for 2026.
1463	Review of Cost Savings Arrangements	2024	Recommendation 1.2	R1.2: The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities (IHCs) through: R1.2: Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan Health Board savings target.	R1.2 The articulation of demand and capacity by speciality and comparison to national metrics will enable allocative efficiency models to be endorsed. This will depend largely upon formation of the above speciality plans and Corporate benchmarking that will occur prior to and during 2025/26.	Russell Caldicott, Executive Director of Finance	31/10/2025			Work is continuing on exploring the opportunities identified to ensure they are sufficiently robust to incorporate to the 2026/27 financial plan.
1467	Review of Cost Savings Arrangements	2024	Recommendation 2.3	R2.3: The Health Board should strengthen its approach to the identification and delivery of savings by: R2.3: Maintaining a focus on the identification of saving schemes that deliver recurrent savings.	R2.3 The Annual Plan (endorsed by the Board) sets out the expectation to deliver the annual savings requirement on a recurrent basis. The 2023/24 Full Year Effect (FYE) outturn was £26.3m which was in excess of the required target £25.2m. The 2024/25 current recurrent FYE forecast against the £48m Savings Target stands at £39.2m (at Month 6).	Russell Caldicott, Executive Director of Finance	31/03/2025			As at month 8 savings are estimated to deliver at £43.4m. The FYE impact of the recurring savings and additional income generation is £32.8m
1470	Review of Cost Savings Arrangements	2024	Recommendation 3.1	R3.1: When updating its savings guidance, the Health Board should ensure: R3.1: That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas.	R3.1 The Health Board launched Small Change Big Difference in 2023, which sought ideas from all staff. We will continue to progress and follow up on these initiatives to secure enhanced savings delivery.	Russell Caldicott, Executive Director of Finance	Ongoing 2025			This agenda item was deferred and will be rescheduled for a future V & S Programme board shortly.
1514	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	**Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 2. Conwy, Denbighshire & Flintshire local authorities and the Health Board have a WASPI in place since the implementation of the SPOAs. (OWNER: CHC Commisioning Manager)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	01/06/2025	1	This work is progressing via the North Wales Collaborative and Regional Leadership Group.

1520	Urgent and Emergency Care: Flow out of Hospital – North Wales Region	2024	Improving the quality and sharing of information	R9. The Health Board and local authorities should implement ways in which information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	**Sub-regional: THIS RECOMMENDATION CONSISTED OF 8 DIFFERENT ACTIONS, AND HAS BEEN SPLIT DOWN TO SEPARATE RECOMMENDATIONS - SEE 1363-1372 AND 15-14-1520)** 8. Actively seek ways to increase local authority access for systems held within BCUHB. (OWNER: Acting Assistant Director of Care Homes Support)	Tehmeena Ajmal, Chief Operating Officer	31/10/2024	31/04/2025	1	There is limited progress on a system for the LAs to access information on POCDs and D2RA Dashboards. Information is shared following Census day to all LAs and the opportunity for bespoke reports have been made available. Progress has been made in allowing Social Care staff working on the acute sites to have access to Right Patient, Right Place dashboards that show the D2RA pathways for patients and EDD. In the West the dashboard now includes Community Resource Team capacity and demand - this will be rolled out across the region.
1717	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	**R9** To help health and care staff adequately signpost and refer people to the right urgent and emergency care services, the Health Board should establish a mechanism to keep the WAST Directory of Services up to date, which includes the identification of an officer with lead responsibility for this task.	R9: A clinical lead has been identified to roll out our Single Point of Access model, which includes an accurate and up to date directory of services to support referral into appropriate services. This will initially be supported by the 6 Goals project team. The lead role will be designated following the reconfiguration of services.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			In addition to the wider UEC programme clinical lead, a separate clinical lead has been appointed providing 2 x SPAs to provide specific focus on the implementation of a single point of access (SPOA) through UEC Workstream 1 and is aligned to the national SPOA framework. Work is continuing to progress within this area against the 6 goals.
1718	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	**R10** To ensure compliance with the national SDEC referral criteria and guidance, the Health Board should conduct an audit of its SDEC data and report the results to the appropriate committee.	R10: As part of the 6 Goals programme a review will be undertaken to evaluate the SDEC models currently in place on each of the 3 acute sites in North Wales, including an analysis of utilisation by WAST and ED to support streaming, and outcomes for patients. The NHS P&I team are conducting an assurance review of the SDEC units during October 2025.	Tehmeena Ajmal, Chief Operating Officer	31/03/2026			Assurance visit took place in Q3 and a report has been produced with key recommendations. These have formed planning for 2026/27.
1719	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	To ensure Urgent Primary Care Centres are being maximised, the Health Board should: **R11.1** Work with key partners, including GPs and Emergency Department leads, to review the UPCC referral criteria.	R11.1: BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			no update issued yet
1720	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Maximising use of SDECs and UPCCs	To ensure Urgent Primary Care Centres are being maximised, the Health Board should: **R11.2** Ensure the UPCC referral criteria is well-communicated and accessible to relevant staff, once agreed.	R11.2: BCUHB is currently working with the Performance and Improvement Team to pilot a test of concept for an Urgent Treatment Centre in Wrexham Maelor. It is likely that the current UPCC model will change significantly and key clinicians will be involved in this process.	Tehmeena Ajmal, Chief Operating Officer	30/06/2026			Wrexham pilot for fraility underway. Concerns around costs and ability to duplicate pan BCUHB.
1724	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Reporting of expenditure of additional funding for UEC services	**R15** To increase transparency and strengthen assurance that monies allocated to the Health Board for urgent and emergency care is being spent wisely, the Health Board should include information on its use of additional funding within regular finance reports to the Performance, Finance and Information Governance Committee. This should include the use of Six Goals, Further Faster and Regional Integration Fund monies	R15: The UEC (6 goals) programme board approved the 6 Goals financial plan that is aligned to the 6 Goals programme plan prior to submission to WG earlier this year. The UEC / 6 Goals programme board will receive regular finance reports on UEC / 6 Goals and wider Further Faster / RIF funding as a standing item which includes review with LA partners.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025			Both internal and external 6 goals board set up and fully mapped for the year with workstreams aligning too. Programme plan for 2025/26 was not agreed by the national team. Plan for 2026/27 submitted and BCU are awaiting feedback.

AUDIT RECOMMENDATIONS AWAITING LEAD EXECUTIVE CLOSURE APPROVAL

ID	Report Title	Year	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Update at 15/12/2025
1569	Effective Governance - Cancer Services	2025	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage budgets, with regular review of savings and budgets. Where services are not operating within agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	2. Delivering financial balance There is regular reporting of financial performance however the service is forecasting an overspend position at year end and is not forecast to achieve its set savings target.	2. The division took further actions in respect of grip and control of expenditure, with cost reductions & control actions aligned to the control total target issued by the health board being met and exceeded. Further action re delivery of CRES savings resulting achieving an over recovery of targets of £2k. However, it is recognised that a final £1m deficit remains against budget allocated and therefore non-compliant with requirements of Standing Financial Instruction 5.2.2 The overspend is represented by Drug related expenditure and commissioning contracts aligned to demonstratable growth. These issues have been escalated & reported through the health board and the various committees such as Execs & PFIG. Actions • An Oncology business case has been presented with final approval at board pending May 25 to secure recurrent budget. A further business case is ongoing to address further cost pressures linked to demand, activity, quality & governance pan BCU. • Ensure working focus groups such as SACT improvement etc are documented as reports for information or minuted through attendance at PFIG or SLT to demonstrate ongoing improvement for patient safety,	Tehmeena Amjal, Chief Operating Officer	31/03/2026	DGM/Dep DGM weekly meetings with aCFO; monthly PFIG; savings meetings and plan; COO report in Nov 2025; presentation slide for IPEDG 05.11.25.
1611	Effective Governance – Integrated Health Community - East	2025	Limited	High	Objective 2: There are appropriate financial governance arrangements in place to manage the financial position, with regular review of savings and financial position. Where services are not operating within the agreed budgetary allocation, appropriate actions and monitoring arrangements are in place.	2. Accountability Letters A number of IHC East accountability letters for 2024/25 have not been signed, as required by Standing Financial Instructions. Out of a total of 89 letters, 73% (65) have been accepted, 23% (20) have had no response and 4% (4) are outstanding with a valid reason noted (not confirmed).	2. Sign accountability letters.	Tehmeena Amjal, Chief Operating Officer	31/07/2025	AAs now signed.

INTERNAL AUDIT RECOMMENDATIONS FOR AUDIT COMMITTEE FINAL CLOSURE APPROVAL

Recommendations outside Internal Audit review scope

Recommendations approved for closure by Internal Audit following review

ID	Report Title	Year	Overall Report rating - from Jan 2025	Assurance Level	Priority	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Revised implementation date	Number of Revisions	Last update	Expected Evidence of Implementation - included in Internal Audit reports from January 2025 onwards
0246	Financial Control – Receipting of goods and year-end accruals	2023	n/a	Reasonable	High	Matter Arising 1: Procurement guidance and training (Operating)	1. The Executive Director of Finance: • Ensures all staff involved in procurement receive mandatory training in line with the requirements stipulated by the Chief Executive of NHS Wales. • Reviews the evidence provided for Purchase Order 9705645 for £293,787 and ensures it is accounted for in the correct financial year.	1. In relation to training, we have to date focused on the provision of essential guidance and training on year-end processes for BCU colleagues in order the mitigate the risk of expenditure being accounted for across BCU in the wrong year at the 2022/23 year-end. Acknowledgement of this is welcome. The assessment of longer-training training needs and the delivery of an ongoing programme of training across BCU are addressed in the Financial Control Environment Action Plan. In relation to the specific Purchase Order 9705645 we confirmed that this was not accrued for in the 2022/23 year-end. It will be accounted for as appropriate in 2023/24.	Russell Caldicott, Interim Executive Director of Finance	31/07/2023	01/11/2023	1	Item 7 in the Financial Control Environment Action Plan, which is monitored fortnightly by WG in conjunction with Special Measures, includes a learning lessons process. The inclusion of the audit for the 2022-23 financial year provides assurance these lessons have been learned with balances endorsed as true and fair by Audit Wales.	*Report published prior to January 2025*
0258	Data analysis – Triangulation of data	2023	n/a	Limited	High	Matter Arising 1: Triangulation of Data sets using consistent naming conventions (Operation)	1.1a: The Deputy Director of Quality: Continues to support the Quality Lead Manager develop the use of all data quality sets to inform Health Board wide reporting – This should be a priority. Ensures the standardisation of 'Location' within Datix, reviews the data associated with 'Do Not Use' and removes duplication of 'Categories', ensuring an appropriate audit trail where these are amended. Considers and progresses the findings within Paragraphs 2.3 to 2.5 inclusive of the Detailed Findings.	1.1a: Following on from the re-alignment of the quality functions, a new Quality Insight and Systems Team is being created. New standard operating procedures for quality systems such as Datix are being developed which will include standardisation of analysis, reporting and dashboards. Working with the national Once for Wales RLDatix Team, a new locations and services hierarchy was implemented in April 2023 which aligns to national standards under the Once for Wales RLDatix programme and best practice. A change control process will be in place via the SOPs mentioned above. The findings from internal audit will be reviewed with the respective quality governance teams and findings will be shared with the executive-chaired Quality Delivery Group.	Angela Wood, Executive Director of Nursing and Midwifery	31/08/2023	31/11/2023	1	The new team is in place and all posts filled permanent or on internal secondment. A quality systems group is in place with representatives from key teams. The group provides central coordination of system development and approved all system changes. Meeting pack as of the Quality Systems Group provided as further evidence.	*Report published prior to January 2025*
0337	Water Safety	2024	n/a	Limited	Medium pre 01/10/2024	Matter Arising 2: Flushing of little used outlets (Operation)	2.3: Management ensure flushing list signed-off appropriately.	2.3: Instruction sent out by e-mail from Head of Operational Estates on 22nd December 2023 to ensure that a signature is applied to each line and not a single signature covering multiple lines on the flushing register. This action will be monitored at the Water Safety Group.	Stuart Keen, Director of Environment and Estates	23/12/2023		0	An e-mail with instruction relating to ensuring that a signature is applied to each line and not a single signature covering multiple lines on the flushing register was sent from the from Head of Operational Estates on 22/12/2023, and this is included as evidence to support closure.	*Report published prior to January 2025*
0352	Deprivation of Liberty Safeguards (DoLS) - 2024	2024	n/a	Limited	Medium pre 01/10/2024	Matter Arising 1: MCA training levels 1 and 2 (Operation)	1.1a (iii): Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.	1.1a (iii): Review current BCUHB training policies and procedures with service leads for Bank, Locum and Honorary staff to ascertain current agreements in place in relation to the completion of MCA training prior to and during employment.	Angela Wood, Executive Director of Nursing and Midwifery	30/09/2024	31/12/2024	1	All mandatory training for Bank, Locum, and Honorary Staff will include MCA Level 1 and Level 2 (where applicable) and this is now extended to Agency Staff and any new 'on-boarded' Agency Staff members. This action is now complete with training data to be supplied monthly to respective services and monitored via the Safeguarding Governance and Performance Group and Mental Health Legislative Committee.	*Report published prior to January 2025*

0455	Operating Model	2024	n/a	Unsatisfactory	High	Matter Arising 1: Operating Model (Design and Operation)	1.1(b) The Health Board, through the Chief Executive should undertake a full review of the operating model including: • A review of the Operating Model, as implemented, to ensure it is fit for purpose in delivering the Corporate/Strategic Objectives, long-term strategy/medium term plan of the Health Board. • A review of all twenty-six services identified as 'Outstanding Design – Clinical' with urgency, noting some represent current risk to the Health Board. • Review of the role, remit and accountability of corporate posts where the services they oversee are delivered through Operational Services, for which they have no delegated responsibility or accountability. • A review of funding, to ensure any Operating Model/Structure is affordable and transparency in funding is ensured.	1.1 (b) Arana (external consultancy) was commissioned in November to undertake an initial review of the operating model. The Chief Executive, supported by the Senior Associate Director of People in May 2024, will commence an engagement process with the Board and other colleagues to consider changes to the organisational structure. This will take account of the gaps in assurance that have been identified as part of this internal audit.	Carol Shillabeer, Chief Executive	30/06/2024	31/03/2026	1	Work continues engaging with staff groups as part of developing the new model. Work stream meetings set up for the 5 work streams that present highlight reports to the programme board. The implementation should be 31.03.2026	*Report published prior to January 2025*
0473	Discharge Arrangements	2024	n/a	Limited	High	Matter Arising 3: Pathways of Care Delays (Design)	3.1c (iv): Management: • Establish formal escalation framework to address and support resolution of Pathways of Care Delays. • Ensure working practice complies with Welsh Government requirements.	3.1c (iv): Regional action plan refreshed in April 2024 discussed with each IHC and respective LAs to ensure actions align with top delays / areas of challenge and submitted to NHS Exec (quarterly). QUARTER 4	Imran Devji, Interim Chief Operating Officer	31/03/2025			The HB has to produce this for WG and this is reported via the RPB. Example action plan can be submitted for evidence. Each month the RPB partners meet with National Lead PG6 to review the data - data set can be provided for evidence	*Report published prior to January 2025*
0490	Health and Safety - 2024	2024	n/a	Limited	High	Matter Arising 2: Monitoring and reporting of Health and Safety (Operation)	2.1b: The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE	2.1b: To ensure that reports are received by the Chair of SOHSG from all relevant areas, TOR to be recirculated to departmental leads, chair of SOHSG needs to be an Executive Director in order to be quorate so will need to be appointed by Executive team. Will be included in SOHSG reports from 2nd Quarter 2024 through People and Culture Committee, responsibility of responsible Executive Director	Carol Shillabeer, Chief Executive	29/02/2024			Included in Terms of Reference for the People and Culture Committee and the also the Health and Safety Policy	*Report published prior to January 2025*
0492	Health and Safety - 2024	2024	n/a	Limited	High	Matter Arising 4: Health & Safety Reviews (Corporate Health & safety) (Design)	4.1: Health Board Policy 5.3.4 is reviewed to ensure that all Corporate Health & Safety recommendations are agreed, assigned to owners, allocated appropriate dates and are subject to follow-up	4.1: New Process already instigated to ensure that a timetable for H&S visits by the corporate H&S team takes place over the coming year with a minimum number of visits per advisor, but also to ensure the quality of the response. It is the responsibility of Managers within the Health Board to assign and follow up responsibility of IHC/Divisional Director	Carol Shillabeer, Chief Executive	01/01/2024			Cohort 1: April - East IHC, Central IHC, West IHC (DGHs only), Environment and Estates, Radiology, and MHLD, took part in the Health and Safety Self Assessment. Work is progressing as set out in the paper to the Executive Committee and presentation given to People and Culture Committee. Cohort 2 will commence in October – Cancer Services, Womens and Maternity Services, Community Services, Pan Services, Corporate Services, and Primary Care.	*Report published prior to January 2025*
0496	Health and Safety - 2024	2024	n/a	Limited	Medium pre 01/10/2024	Matter Arising 7: Self Assessments (Design)	7.2: An up-to-date list of Health and Safety leads / champions be developed to ensure there are contacts in place for all departments who are required to undertake self-assessments	7.2: To work with comms and managers of areas to ask for H&S leads for each area as part of generic work to be done on ensuring all areas conduct regular self-assessments	Carol Shillabeer, Chief Executive	01/05/2024			H&S Advisors in East, West and Central are all participating in INCC Safety meetings and reinforcing the need for the IHC managers to take ownership, above the regular reviews carried out by the corporate team. The following is attached as evidence to support closure from Centre, East and West: • H&S minutes • H&S reports, timetable	*Report published prior to January 2025*
0531	Digital Operating Model	2023	n/a	Reasonable	High	Matter Arising 3: Business Relationships (Operation)	3.3: IHCs and Divisional Directors should seek to include digital within the standard agendas and working of the three IHCs and clinical divisions/directorates with good amount of time allocated to this priority.	3.3: The inclusion of digital within the standard agendas and working of the three IHCs and clinical divisions/directorates to be raised with IHC and Divisional Directors.	Dylan Roberts, Chief Digital and Information Officer	31/01/2024			All IHC's have digital on their agendas. Each IHC reporting is different though and where digital is reported. Business Relationship Manager is now in post so cover in place for attendance and reporting at the meetings.	*Report published prior to January 2025*

0564	Clinical Audit - 2022	2022	n/a	Limited	High	Matter Arising 2 – Annual Clinical Audit Plan (Operation)	2.2a: Justification for each of the reviews included within the plan should be retained by the Clinical Effectiveness department.	2.2a: Management comment There is a need for more clarity from key stakeholders on what is expected from Tier 2 project and what is required from project leads, this would help improve the information when sharing, such as: • providing the required information on the project, for example risks, methodology, the aim of the project • how local stakeholders will progress taking project forward and outline how the audit results are going to drive improvements • clear progress updates provided to the Clinical Effectiveness team on quarterly basis throughout the year, including action planning when complete or a rationale of why a project has not progressed in year as planned Complete 30th September 2022 (sub: to release of operating model) • wider information required from the project lead at point of suggesting topic (or retrospectively for this year), which clearly identifies the rationale for the project, risks, methodology, and aim (refer to attached gap analysis document) The Clinical Effectiveness team have been introducing the new management/tracking software, Audit	Nick Lyons, Executive Medical Director	30/02/2022			AMaT has now been implemented in the Health Board, and is being utilised to capture actions from clinical audits, and provides greater facility to document actions. Suggest this is put forward for closure as this is a historical recommendation.	*Report published prior to January 2025*
1221	Mental Health & Learning Disabilities Division	2023	n/a	Reasonable	High	Matter Arising 2: Ligature remediation funding (Operation)	2.1e MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	2.1e: Chair of the MH&LD Divisional Service Quality Group to provide a monthly assurance report into MH&LD Senior Leadership Team meeting including high risk anti-ligature works for any required capital expenditure.	Iain Wilkie, Interim Director MHLD	31/03/2023			Monthly MHLD Ligature Risk Reduction Group (DLRG) Reports into MHLD DSLT Business meeting. Copy of the MHLD Ligature Risk Reduction Group (DLRG) Report presented in 25th June 2024 meeting embedded as evidence. In addition an MHLD Ligature Risk Reduction Group (DLRG) Report including an update on door top alarms was also presented to the MHLD DSLT Business meeting held on the 18th June 2024. Action to be marked as complete.	*Report published prior to January 2025*
1222	Mental Health & Learning Disabilities Division	2023	n/a	Reasonable	High	Matter Arising 2: Ligature remediation funding (Operation)	2.1f MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	2.1f: MH&LD Division to commission an external review of all MH&LD inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division.	Iain Wilkie, Interim Director MHLD	31/03/2023			The MH&LD Division commissioned an external review completed by Tony Crumpton to review all the inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Heddfan and Coed Celyn were completed in June 2023, Ablett and Bryn Hesketh were completed in August 2023, and the West area were completed in October 2023.	*Report published prior to January 2025*
1223	Mental Health & Learning Disabilities Division	2023	n/a	Reasonable	High	Matter Arising 2: Ligature remediation funding (Operation)	2.1g MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	2.1g: Each local Ligature Reduction Group to report on progress aligned to the external review report recommendations, included within Chairs exception report feeding into the Divisional Ligature Risk Reduction meeting.	Iain Wilkie, Interim Director MHLD	30/04/2023			The MH&LD Division commissioned an external review completed by Tony Crumpton to review all the inpatient environments for ligature assessment to produce a report to identify high, medium and low risk ligature reduction work required across the Division. Heddfan and Coed Celyn were completed in June 2023, Ablett and Bryn Hesketh were completed in August 2023, and the West area were completed in October 2023.	*Report published prior to January 2025*

1224	Mental Health & Learning Disabilities Division	2023	n/a	Reasonable	High	Matter Arising 2: Ligature remediation funding (Operation)	2.1h MHLD management ensure all ligature risk assessments remain 'live' and subject to regular scrutiny to mitigate/control identified risk.	2.1h: MH&LD Division to arrange an audit to check the governance arrangements for anti-ligature are implemented and consistently being met, with an exception report being fed into Divisional Ligature Reduction group highlighting any variance aligned to standards.	Iain Wilkie, Interim Director MHLD	30/06/2023			MH&LD audit schedule completed in October 2023. Fieldwork completed the report will be compiled and the expected date for the report will be mid-November. The template developed for exception reporting from each of the MH&LD SLT includes a section to escalate any variance aligned to the standards. The MH&LD Division and Health & Safety have arranged additional training for the MH&LD Division to undertake ligature assessments. This training will assist in the consistent application of procedure and assessment processes. The attached procedure has been updated following guidance from the Care Quality Commission Brief Guide: Ligature anchor points, ligatures and other means of self-harm using fixtures and furniture (CQC 2022). The procedure emphasises the importance of considering multiple factors in assessing the risk posed by ligature points. Action marked as complete	*Report published prior to January 2025*
1317	Recruitment of substantive and interim executive and senior posts Final Internal Audit Report	2024	n/a	Reasonable	Medium pre 01/10/2024	Matter Arising 4: Procurement Training (Operation)	4.1 The recording of all procurement training, as required by the Welsh Health Circular and Accountability Agreement is ensured by assigning 050|LOCAL| Procurement Financial Training - 3 Years | Information and Knowledge to mandatory training for: • All Executive and Board level Directors, including direct reports to the Chief Executive. • All Officers in receipt of Accountability Agreements. • All other Officers involved in Procurement. • All officers who have completed the training to date, up to a minimum time e.g. 1 hour or more have their record updated in ESR.	4.1 The process of updating competencies will be reviewed and updated to ensure new and existing Board level Directors and staff receive the ESR competency and that Remuneration Committee will receive routine updates on compliance with this training requirement.	Carol Shillabeer, Chief Executive	28/02/2025	30/05/2025	1	All Executive Team members undertook training around procurement with the NWSSP Head of Operational Procurement and National Sourcing on 03/12/2025.	*Report published prior to January 2025*
1337	Orthopaedic Surgical Hub Llandudno Hospital - 2024	2024	n/a	Limited	Low	Matter Arising 8: Design sign off (Operation)	8.1: Noting that meetings to discuss design are now held virtually, consideration should be given to how formal sign off can be captured in the future.	8.1: Agreed - Meetings to confirm sign off have been recorded in teams and some responses have also been confirmed by email as evidence. We will review alternative approaches that support virtual sign off going forward.	Russell Caldicott, Executive Director of Finance	31/08/2024	30/09/2025	1	There is now a monthly meeting – minutes of last meeting attached which records decisions	*Report published prior to January 2025*
1378	Intelligence Led Organisation	2024	n/a	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.3.3 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and	1.3.3 **Understanding Requirements** Data warehouse roadmap to be documented (Q4 milestone in DI&I 2024/25 annual plan).	Dylan Roberts, Chief Digital and Information Officer	31/03/2025			The roadmap has been established through the draft Digital Roadmap and Data Strategy documents. Three workstreams are in place to implement the required technical changes and develop detailed delivery plans.	*Report published prior to January 2025*
1380	Intelligence Led Organisation	2024	n/a	Reasonable	Medium	Matter Arising 1: Skills (Operation)	1.3.5 A DI&I workforce plan should be developed, based on assessment of current and future needs for information and include an identification of skills required together with staff levels. The plan should consider various methods for obtaining skills and resource including: • creating time for staff to develop their skills and experiment with tools; • partnering with universities in order to obtain advanced skills and share learning; • partnering with third part organisations in order to access resource; and	1.3.5 **Understanding Requirements** Develop training programme based on TNA and scoping of available learning materials (DDaT Workforce strategy action).	Dylan Roberts, Chief Digital and Information Officer	28/02/2025	30/06/2025	1	High level training strategy in place	*Report published prior to January 2025*

1404	Charitable Funds - 2024	2024	n/a	Reasonable	Medium	Matter Arising 2: Policy and procedures (Operation)	2.1a) Fund Advisor list is routinely reviewed to ensure compliance with Your Charity Procedures.	2.1a) The Fund Advisor list is to be regularly reviewed monthly by the Charitable Support Team	Russell Caldicott, Executive Director of Finance	30/04/2025			Update complete including signing of accountability agreements for 25/26. Monthly reviews to take place for changes at charity team meetings. Evidence supplied for closure	*Report published prior to January 2025*
1407	Charitable Funds - 2024	2024	n/a	Reasonable	Medium	Matter Arising 2: Policy and procedures (Operation)	2.2a) Accountability Agreements are re-established and controls are in place to manage and maintain compliance – we acknowledge that work is currently underway on this issue.	2.2a) Accountability Agreements (Fund Advisor Accountability Agreement 2024/25) are issued to all existing Fund Advisors for completion	Russell Caldicott, Executive Director of Finance	30/04/2025			Update complete including signing of accountability agreements for 25/26. Monthly reviews to take place for changes at charity team meetings. Excel file attached for closure	*Report published prior to January 2025*
1486	Network and Disaster Recovery	2024	n/a	Reasonable	High	Objective 1: The digital infrastructure is maintained with appropriate physical security, monitoring, support, and risk management in place.	R3.3: **Environmental Controls** We noted some specific weaknesses in the environmental controls over Digital areas and datacentres.	R3.3: Review and improve power supply in Ysbyty Glan Clwyd.	Dylan Roberts, Chief Digital and Information Officer	30/09/2025			Work completed April 2025.	Copy of Standard Operating Procedure, email to all staff, Capital Bid, Design Documentation, ICT Work Plan. (same evidence as 1484-1485 and 1487-1488)
1488	Network and Disaster Recovery	2024	n/a	Reasonable	High	Objective 1: The digital infrastructure is maintained with appropriate physical security, monitoring, support, and risk management in place.	R3.5: **Environmental Controls** We noted some specific weaknesses in the environmental controls over Digital areas and datacentres.	R3.5: Outcome of above actions will transfer onto the ICT Work Programme for future implementation and monitoring.	Dylan Roberts, Chief Digital and Information Officer	30/09/2025			An online Critical Infrastructure Hosting Audit Form developed - each facility will be subject to an annual audit by the Cyber Security and Compliance Team. This requirement has been added to the Cyber Security Work Programme. Please find attached Critical Infrastructure Hosting Audit Sheet.pdf and Cyber Work Plan.png	Copy of Standard Operating Procedure, email to all staff, Capital Bid, Design Documentation, ICT Work Plan. (same evidence as 1484-1487)
1513	Transformation and Improvement	2025	Reasonable	Limited	High	Objective 3: Progress and achievements are reported through to the Health Board via its Committees / Groups to provide assurance.	3. **Assurance reporting** We have been unable to determine the Transformation and Improvement team are subject to effective oversight or scrutiny through their reporting via the Health Board's governance structure, concerning areas they are supporting or accountable for through to whether changes made in transformation have made a difference.	3. Agree schedule of regular oversight reporting to the Executive Committee through to the appropriate Board Sub Committee	Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning	30/04/2025			Major Change programmes report directly to the Executive Committee via AAA reporting. The Strategic Planning and Service Change Group, a sub group of the Executive Committee chaired by the CEO, oversees the overall programme of work, and the PPHP committee of the Board now receives a Director of Planning report as a standing agenda item, a new development that has been well received by Board members. Propose to close. **Evidence** Slide re: reporting Example AAA report SPSCG ToR Director of Planning Report	The reporting of transformation and improvement progress and outcomes is documented and delivered through the established Health Board governance structure, thus demonstrating whether the investment and change has made a difference and improved services for patients.
1568	Effective Governance - Cancer Services	2025	Limited	Limited	High	Objective 1: There is an appropriate governance and reporting structure in place within the service to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external reviews such as Healthcare Inspectorate Wales and Audit Wales	1. Governance arrangements The Terms of Reference (ToR) for the Senior Leadership Team sets out the remit of the group, and there is a standing agenda item which includes all areas for discussion at each meeting. A review of the minutes for January, February and March 2025 meetings show that whilst most areas on the agenda are discussed within the PFIG Update – Performance, Finance, Information Governance item, there was no update provided on Cancer Pathway Performance at the January and February meetings. We also noted through reports to the Health Board and Committee that performance is not at a level it should be but found minutes did not record specific action to improve on performance.	1. It is noted that PFIG updates to the SLT on the Cancer Pathway performance were not provided during January and February meetings due to annual leave of the cancer network lead. An update was presented at the 17th March 2025 meeting evidenced in the minutes. PFIG updates on the cancer pathway performance will continue to be provided as a standing agenda item to SLT with contingency arrangements in place to ensure cover during leave.	Tehmeena Ajmal, Chief Operating Officer	30/06/2025			Notes of Cancer Service Senior Leadership Team meetings on 9th June and 23rd June are provided as evidence of PFIG updaets provided at the SLT meetings. It is noted however the improvements for delivering performance on cancer targets is within the responsibility of the IHCs and more detailed discussions are held at the Single Cancer Pathway Delivery Group with IHC leads and wider services - an action log of this Group is also provided as evidence of actions arising from discussions at this forum . It is recommended that this action is now completed and approval for closure.	Minutes / agenda of the SLT including updates on all matters of performance with actions noted to recover and improve the reported position.
1574	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Limited	High	Matter Arising 2: Declare System (Operation)	2.1 (a) To review the process for Declarations for Board Members and Executive Team.	2.1 (a) Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	30/09/2025			The register is now linked to our website	Process documented and approved, live register available on the website.
1576	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Limited	High	Matter Arising 3: Audit Committee Reporting (Operation)	3.1 The Business Cycle for Audit Committee to be reviewed to ensure it is consistent with the Standards of Business Conduct Policy.	3.1 Management: • Review reporting arrangements and ensure staff declarations are subject to Audit Committee oversight and scrutiny in line with policy requirements.	Pam Wenger, Director of Corporate Governance	31/08/2025			Regular Corporate Governance Report which will include Declarations of Interest updates presented to Audit Committee.	Business Cycle approved by Audit Committee.

1577	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Limited	High	Matter Arising 4: Board Members declarations of interest (Operation)	**SAME AS 2.1 (a)** 4.1 (a) The Director of Corporate Governance: • Ensures Board Member declarations are accurate and comprehensive throughout the year – not limit due diligence work to year end. • Reminds Board Members of the requirement to declare all outside employment as part of their mandatory annual declaration of interest, and to notify the Office of the Board Secretary (Corporate Governance Directorate April 2024 onwards) of any changes as and when they arise. • Ensures the public register of Board Member interests is maintained and kept up to date.	**SAME AS 2.1 (a)** 4.1 (a): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	30/09/2025			These are live and on the website	Process documented and approved, live register available on the website.
1579	Standards of Business Conduct – Declarations of Interest, Gifts and Hospitality - follow-up	2025	Limited	Limited	High	Matter Arising 5: BCU staff declarations of interest (Operation)	**SAME AS 2.1 (a)** 5.1 (a) Management: • Ensure line mangers are aware of their responsibilities regarding approving declarations of interest (and gifts and hospitality). • Ensure staff understand when, and how often, a declaration should be made. • Establish controls and /or oversight arrangements to manage and escalate non responses (from Decision Makers) and failure to approve (by line managers). • Ensure data extracted from Declare is reviewed and adjusted appropriately prior to reporting (e.g. to Audit Committee).	**SAME AS 2.1 (a)** 5.1 (a): Management: • Ensure all scheduled notifications are functioning as intended. • Ensure published data is accurate and can be reconciled to source data. • Ensure published guidance documentation is consistent with NHS Wales requirements and relevant to Health Board staff.	Pam Wenger, Director of Corporate Governance	30/09/2025			These are live and on the website	*Not included in follow-up report*
1610	Effective Governance – Integrated Health Community - East	2025	Limited	Reasonable	Medium	Objective 1: There is an appropriate governance and reporting structure in place within the IHC to provide assurance on services and ensure oversight of all areas of responsibility. Reporting includes ward to board assurance, audit results, ward accreditation information and monitoring of actions resulting from external reviews such as Healthcare Inspectorate Wales and Audit Wales.	1. Governance East IHC have established the required governance structure in line with that approved by the Health Board. We reviewed Terms of Reference, cycles of business and minutes for several group meetings, identifying the following gaps: • Identification of both the Chair and Vice Chair was not recorded in the ToR of the Senior Leadership Team (SLT). • Minutes of the Quality Delivery Group meeting held on 26 November 2024 recorded that low attendance has been noted with acknowledgement that the Senior Leadership Team are reviewing all IHC Meetings to avoid duplication. • Minutes of the Finance & Performance meeting held on 27 November 2024 noted that it was not quorate however group decided to proceed and any items for approval to be escalated to SLT for a decision. • Minutes of the People and Culture Meeting on 15 October 2024 show poor attendance with (5) Apologies recorded and (23) Non-Attendees/No Apologies Noted.	1. Review Terms of Reference in line with updated SORD and Foundations for the Future.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025			Reviews have taken place and TOR and meeting notes supplied for closure.	Updated version of SLT TOR. Minutes of meetings evidencing appropriate attendance in line with agreed ToRs.
1614	Effective Governance – Integrated Health Community - East	2025	Limited	Reasonable	Medium	Objective 4: Complaints, concerns, incidents and staff concerns (via Speak Out Safely) are investigated, reviewed, and responded to in a timely manner. Learning from these is captured and reviewed / shared as appropriate.	5. Open / Closed Incidents The number of incidents is a cause for concern and management should put arrangements in place to close open and overdue incidents. The number of new incidents as of March 2025 has risen to 171 from 38 in February 2025. Also the number of closed incidents has dropped to 484 from 739 for the same periods.	5. Develop and agree recovery plan.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025			The IHC have a trajectory plan - evidence supplied to support closure	Evidence of a plan / arrangements in place to close open and overdue incidents.
1615	Effective Governance – Integrated Health Community - East	2025	Limited	Reasonable	Medium	Objective 5: Risk management processes are embedded throughout the IHC and are in line with the risk strategy in terms of risk registers and regular review of risks.	6. Review of risks Risk Management processes are embedded throughout the IHC, and the risk registers reviewed were in line with Risk Management Procedures, however there are a number of risks that are overdue and require updating.	6. Review and update risks at IHC and portfolio levels.	Tehmeena Ajmal, Chief Operating Officer	30/09/2025			Risks are discussed monthly at the Risk Management meeting - evidence to support closure provided	Risk register with all risks reviewed / updated.

1645	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	Unsatisfactory	High	Objective 3: Project Governance	3. **Project Board meetings** The minutes from the January 2025 Project Board meeting could not be accessed due to a technical issue with the recording software. It was confirmed that the minutes were not recoverable. Additionally, no Project Board meetings were held in February or March 2025. The organisation had advised that meetings were expected to resume in April 2025. The Project Board's Terms of Reference required meetings to be held monthly. Given the status of the project in relation to Time, Cost, and Quality parameters, this lapse in governance and oversight during a critical phase is of particular	3. Board meetings were not undertaken following the Senior Responsible Officer Executive Director leaving the Health Board. These meetings have re-commenced and evidence can be provided as required to confirm this to be the case.	Russell Caldicott, Executive Director of Finance	31/03/2026			All Project Board meetings have agendas, minutes and action logs. Link to sharepoint site provided as evidence - need to request access to view.	Minutes of the meetings
1651	Orthopaedic Surgical Hub Llandudno Hospital - 2025	2025	Unsatisfactory	Limited	High	Objective 5: Validation of costs and contractual payments	9. **Retention figure** Noting that the agreed 5% contract retention has subsequently been reduced to reflect the Main and sub-contractors' requirements. Noting the key change in the agreed contract conditions and award criteria, formal Project Board scrutiny/challenge and approval of the same was not evidenced.	9. The process for movement on retention values will be documented in the revised Scheme of Reservation and Delegation.	Russell Caldicott, Executive Director of Finance	31/10/2025			The revised SORD was approved by Board on 25 September 2025	Reference to delegation route for decisions on retentions to be referenced within the Scheme of Reservation and Delegation
1656	Corporate Legislative Compliance: Civil Contingencies Act 2004	2025	Limited	Reasonable	Medium	Objective 1: There are effective governance arrangements in place to ensure the Health Board is meeting their obligations as a category 1 responder, with appropriate oversight and scrutiny of arrangements	**1. Escalation process** As a Category 1 responder, the Health Board is required to have robust business continuity plans in place. Several departments have not submitted current BCPs and while 47 BCPs are live, a significant number (43) are still awaiting Director sign-off (see objective two for further information). Whilst work is ongoing to improve the number of departments who have submitted plans, there is no formal escalation process in place to ensure non-compliance with this requirement is addressed. For example, service leads could be required to explain non-compliance at CCAG meetings and further issues should then be escalated to PPHP.	1) To create a dashboard reporting mechanism to show denominators, % of compliance and the introduction of a RAG system to easily identify high risk areas. 2) To create a mapping template to forward to the IHCs, Pan BCU and Corporate Teams to identify their denominator (ie number of services that require a Business Continuity plan). 3) By way of formal escalation process, to report all compliance from the dashboard summary to the Civil Contingencies Assurance Group (CCAG) quarterly, or upon request identifying areas of non-compliance where action is required.	Jane Moore, Executive Director of Public Health	31/12/2025			1) The Business Continuity Dashboard is now live to colleagues updating the work. A full compliance dashboard is reporting daily and via the CCAG group. CLOSE 2) The mapping template has been shared with all areas and completed. CLOSE 3) Monthly BC reports are being circulated to the CCAG and BC leads. Also reporting through CCAG. CLOSE	Papers / minutes of the CCAG meeting / PPHP meeting showing reporting of completion rates of business continuity plans. Where there is continued non-compliance, evidence that these departments have been highlighted and escalated appropriately.
1664	Patient Experience	2025	Reasonable	Reasonable	Medium	Objective 2: Feedback is used to inform and drive improvement throughout the organisation, with evidence of action taken to address identified issues and share good practice	2. We have been unable to observe the First Ministers briefing being shared within the Health Board's governance structure i.e. Executive Committee through to Quality, Safety and Experience Committee.	A protocol/operational procedure will be published whereby all First Minister/Minister briefings are routed via the Chief of Staff for issue.	Angela Wood, Executive Director of Nursing and Midwifery	03/10/2025			A protocol/operational procedure has been published whereby all First Minister/Minister briefings are routed via the Chief of Staff for issue. New process established and returns are reviewed and approved by the Executive Director of Nursing and Midiwfery and then issued via the Chief of Staff.	First Minister briefing progress through the Health Board governance route for assurance e.g. presented to Executive and/or Quality Safety and Experience Committee as part of the reports presented for information.

EXTERNAL AUDIT RECOMMENDATIONS AWAITING LEAD EXECUTIVE CLOSURE APPROVAL

ID	Report Title	Year	Finding title	Key Finding	Agreed Management Action	Executive Lead	Original implementation date	Update at 15/12/2025
1708	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Identifying data used to inform plans for urgent and emergency care	**R1** 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.	R1. 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.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025	Details can be found within the 6 goals plan and IMTP
1714	Urgent and Emergency Care: Arrangements for Managing Demand	2025	Improving information on alternative services	**R6** 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	R6 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.	Tehmeena Ajmal, Chief Operating Officer	31/12/2025	Winter Communications Campaign Plan - we have published 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. Evidence attached for closure

ALL OVERDUE POLICIES

INFORMATION CORRECT AS AT 05/03/2026

Name	Review Date	Responsible Director	Q4 2025/26
ISU03 - Volunteering Policy - V0.1.pdf	12/01/2017	Executive Director of Workforce and Organisational Development	No update received.
TU1 - Policy & Procedure for Top up Payments - V0.2.pdf	01/05/2017	Executive Medical Director	Awaiting names of local contacts for policy, will then go to DTG - in progress.
PTR02 - Claims Management Policy.pdf	05/06/2017	Director of Corporate Governance	This is being progressed, and will be in place by end of Q4 2025/26
MD10 - Medical & Dental Staff Study Leave Policy - V0.1.pdf	20/10/2017	Executive Medical Director	Policy owner changed, also will be under review to move to W&OD Will be moving to W&OD once gone through process ST/L is out for consultation at the moment with JLNC
MD11 - Medical & Dental Staff Professional Leave Policy - V0.1.pdf	20/10/2017	Executive Medical Director	Policy owner changed, also will be under review to move to W&OD Will be moving to W&OD once gone through process
MD13 - Annual Leave & Special Leave Policy for Medical & Dental Staff - V0.1.pdf	20/10/2017	Executive Medical Director	Policy owner changed, also will be under review to move to W&OD They will both go to the full JLNC in April for approval
WP52 - Study Leave Policy - (Applies to all staff apart from Medical & Dental) - V0.2.pdf	01/01/2018	Executive Director of Workforce and Organisational Development	No update received.
NHS Wales Social Media Policy - V0.10.pdf	07/01/2018	Executive Director of Workforce and Organisational Development	No update received.
All Wales Email Use Policy - V2.pdf	26/06/2018	Chief Digital Information Officer	No update received.
RD04 - NHS R&D Finance Policy - V1.0.pdf	20/07/2019	Executive Medical Director	This is an All Wales SOP where HCRW update
CW01 - BCUHB Paediatric Escalation Policy - V3.pdf	01/09/2019	Chief Operating Officer	No update received.

WP29 - BCU Relocation Expenses Policy V0.3.pdf	05/12/2019	Executive Director of Workforce and Organisational Development	No update received.
MHLD 0027 - BCUHB Mental Health Division - Open Door Policy - V0.1pdf.pdf	01/07/2020	Executive Director of Allied Health Professions and Health Science	No update received.
All Wales Policy on Insurance, NHS Indeminity & related Risk Management for Potential Losses & Special Payments.pdf	11/09/2020	Executive Director of Finance	New All Wales policy submitted for final review by policies team and inclusion on PMS Policy Comments - Initial QA check was completed and documents returned on the 21/01/2026. No response has been received since this.
MM05 - Intrathecal Chemotherapy Policy - V3.pdf	01/03/2021	Executive Medical Director	Went to MPPP in January 26 going to DTG w/c 09.02.26 in progress.
MM37 - Medical Gases - Staff Responsibilities across BCUHB - V1.1.pdf	01/05/2021	Executive Medical Director	Looking to combine overarching medical gas policy with MM37 as there is duplication. Also to be discussed with Chief Pharmacist w/c 09.02.26 - In progress.
MD17 - Interventions Not Normally Undertaken (INNU) Policy - V1.1.pdf	01/09/2021	Executive Medical Director	Public HW leading on this
WP11 - NHS Wales Managing Attendance at Work Policy - V0.1.pdf	01/10/2021	Executive Director of Workforce and Organisational Development	No update received.
ES04 - Policy for the Managment of Fire Safety - V0.4.pdf	01/04/2022	Director of Environment and Estates	Policy and associated documents updated and going through approval process - Fire Safety Mtg 18th Dec / SOHSG 16th February 2026
MHLD 0051 - Community Treatment Order Policy MHA 1983 - V0.1.pdf	01/05/2022	Executive Director of Allied Health Professions and Health Science	No update received.

MM02 - Injectable Medicines Policy.pdf	08/07/2022	Executive Medical Director	Slow progress but is progressing, need to ensure it reflects EPMA appropriately as that is a change since the last consultation. Will be sent out to key stakeholders again. Plan going forward is 1. Aiming for it to be completed by June 2. Will get feedback from the working group by end of Feb 3. Stakeholder consultation march 4. Then the various approval committees In Progress
RD03 - Policy for Intellectual Property - V2.pdf	01/08/2022	Executive Medical Director	This is an All Wales SOP where HCRW update
A Clinical Policy for DNACPR For Adults in Wales - V4.pdf	01/12/2022	Chief Operating Officer	No update received.
All Wales Information Governance Policy - V2.pdf	13/01/2023	Chief Digital Information Officer	No update received.
All Wales Information Security Policy - V2.pdf	13/01/2023	Chief Digital Information Officer	No update received.
All Wales Internet Use Policy - V3.pdf	13/01/2023	Chief Digital Information Officer	No update received.
ES03 - Waste Management Policy - V5.pdf	01/09/2023	Director of Environment and Estates	11/02/2026 - Update provided by Stuart Keen, Director of Environment and Estates: Policy Updated IAST and EQIA Completed and awaiting final approval. Approved at Environmental Steering Group.
MHLD 0034 - MHLD Policy for Section 5(2) Doctors Holding Power in Psychiatric Units.pdf	01/10/2023	Executive Director of Allied Health Professions and Health Science	No update received.
MM01 - BCUHB Medicines Policy.pdf	31/12/2023	Executive Medical Director	Ongoing
MHLD 0041 - MHLD Policy for Use of Handcuffs (specific to Ty Llywelwyn Medium Secure Unit).pdf	15/01/2024	Executive Director of Allied Health Professions and Health Science	No update received.
MHLD 0020 - S-CAMHS to Adult Transition Policy - V3.pdf	01/03/2024	Executive Director of Allied Health Professions and Health Science	No update received.
BH-004 - Transfusion of Blood Components Outside the Acute Hospital Setting - V2.0.pdf	01/08/2024	Chief Operating Officer	No update received.
F02 - Lease Car & Pool Vehicle Policy and Procedure - V.03.pdf	15/08/2024	Executive Director of Finance	New policy drafted and out for consultation.

WP69 - Employer Pension Contributions – Alternative Payment Policy.pdf	01/03/2025	Executive Director of Workforce and Organisational Development	No update received.
ES05 - Policy for the Management of Ventilation Systems - V1.0.pdf	08/03/2025	Director of Environment and Estates	To be Discussed in the next Ventilation Group meeting 26th Feb.
HS23 - CCTV and Body Worn Video (BWV) Policy - V1.0.pdf	15/03/2025	Director of Environment and Estates	HS23 is on SOSH agenda under the Title – CCTV and Body Worn Video (BWV) Procedure. Depending on comments this will go to BCUHB webpages for next stage of ratification. The new procedure combines guidance in the old HS23 & HS24 documents so only one procedure will exist in the future. Re-aligned this to the Director of Environment and Estates.
MM03 - Procedure for Supplementary (SP) and Independent (IP) Prescribers (1).pdf	01/04/2025	Executive Medical Director	Unable to update until the new process underpinning the new digital database for NMP has been implemented still in pilot phase, in progress.
MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf	29/04/2025	Executive Director of Allied Health Professions and Health Science	No update received.
ES02 - Policy for the Management of Safe Water Systems.pdf	10/05/2025	Director of Environment and Estates	Water Policy reviewed on Monday 1st December 2025, IAST and EQIA have been updated in readiness of approval within Water Safety Group.
RD02 - Policy for Research Involving Ionising & Non Ionising Radiation.pdf	25/05/2025	Executive Medical Director	This is to be uploaded by radiology colleagues
ES01 - BCUHB Asbestos Policy & Management Plan.pdf	31/05/2025	Director of Environment and Estates	Policy and associated documents updated an going through approval process - Approved at the Asbestos Safety Group Meeting on 10th December 2025 and EQIA completed.
CRF01 - North Wales Clinical Research Facility (NWCRF) - Operational Framework Policy.pdf	15/08/2025	Executive Medical Director	R&D team are now reviewing NWCRF SOPs for them
RD01 - Research Governance Policy.pdf	17/08/2025	Executive Medical Director	To be reviewed by R&D team no major updates from previous version
RES03 - Cardiopulmonary Resuscitation (CPR) Policy.pdf	31/08/2025	Executive Medical Director	10-12 weeks estimated to submission for final approval being reviewed at next Resus meeting 24th March
MD01 - Policy on Consent to Examination or Treatment (Based on the All Wales Model Policy) .pdf	01/09/2025	Executive Medical Director	No update received.

PTR01 – Integrated Concerns Policy .pdf	01/09/2025	Executive Director of Nursing	Endorsed at EQDG 9-2-26
NU33 - All Wales Thromboprophylaxis Policy.pdf	01/11/2025	Chief Operating Officer	No update received.
INF06 - Policy for Clinical Coding.pdf	08/11/2025	Chief Digital Information Officer	No update received.
IPC05 - Outbreak Reporting & Control Policy, Including Major Outbreaks.pdf	20/12/2025	Executive Director of Nursing	Reviewed- out for consultation, for approval SIPG Feb 2026
PC_01 - BCUHB Patient Access to Planned Care Policy .pdf	30/01/2026	Chief Operating Officer	No update received.
OTD-01 - BCUHB Organ & Tissue Donation Policy.pdf	01/02/2026	Executive Director of Allied Health Professions and Health Science	No update received.

Audit Committee

COMPLIANCE WITH THE CORPORATE GOVERNANCE CODE

Dyddiad y Cyfarfod Date of Meeting	21 April 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Approval

**Crynodeb Gweithredol
Executive Summary**

This report provides assurance on the Health Board's compliance with HM Treasury's "Corporate governance in central government departments: code of good practice" for the 2025/26 reporting period, as required by Welsh Government through the annual Manual for Accounts.

A self-assessment has been undertaken against those elements of the Code applicable to NHS bodies in Wales. The assessment demonstrates that the Health Board has complied with the relevant principles throughout the year, with no departures to report.

The exercise has also highlighted areas of strengthened governance maturity during 2025/26, including Board effectiveness, risk management, and assurance arrangements. The outcome of this assessment will inform the statement of compliance within the Draft Accountability Report, which will be considered by the Audit Committee prior to Board approval.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Executive Committee	8 April 26	Approved

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

COMPLIANCE WITH THE CORPORATE GOVERNANCE CODE

1. Y SEFYLLFA / SITUATION

1.1 Each year, the Health Board must confirm whether it has complied with HM Treasury's Code of Good Practice. This paper outlines the Health Board's conformance with the Code for the reporting period.

2 Y CEFNDIR / BACKGROUND

2.1 The DRAFT Accountability report submitted to Welsh Government as part of the end of year arrangements requires the Health Board to confirm whether it has complied with HM Treasury's 'Corporate governance in central departments: code of good practice' and if it has not, outline the reasons as to why. As a result, an assessment was undertaken against each of the sections applicable to the Health Board to demonstrate that it has complied with the code for the duration of the year and can state as such in its accountability report.

2.2 The table below highlights the extract:

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include self-assessment, internal and external Audit, and independent reviews. The Board complies with the relevant principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. **The Audit Committee will receive a report on our compliance to the Corporate Governance Code in April 2026.**

2.3 **Governance and Risk Issues Outlined in the Code of Practice**

The manual for accounts, which is issued each year by Welsh Government, sets out which sections of the code of practice with which the health board is expected to comply. These are set out in the table below (paraphrased for ease) alongside the action taken within the organisation.

In summary the report is able to demonstrate conformance to the Code and has been a useful exercise to highlight progress that has been made during 2025/26 in relation to Corporate Governance.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

Corporate Code of Practice Self-Assessment Review

Requirements of the Corporate Governance Code	How the Health Board Complies
The Role of the Board	
2.1 Each department should have an effective board, which provides leadership, helping it to operate	During 2025/26 Health Board had a full board in place comprising executive directors and independent members.
2.2 The Board forms the collective strategic and operational leadership.	During 2025/26 the Board at BCUHB has overseen the full organisation, including the implementation of the annual plan, organisational strategy providing leadership which is then cascaded throughout the Health Board.
2.3 The Board does not decide policy or exercise the powers of the ministers	Such decisions are made by Welsh Government with the Board advising on and monitoring the implementation. This was the case in 2025/26
2.4 The Board should meet at least on a quarterly basis.	The Board met at least bi-monthly throughout 2025/26
2.7 The Board supports the accounting officer (not the accountable officer)	A report as to the financial position has been received at every Board meeting in 2025/26, supported by reports on issues such as budget setting. There is also a bi-monthly Performance Finance and Information Governance Committee to provide scrutiny and assurance. The Board also established Financial Oversight Group to support the development of a financial recovery plan.
2.12 Where Board members have concerns which cannot be resolved, they should ensure these are recorded in the minutes.	Members highlight any issues they wish to be recorded during the meeting but there is also opportunities to raise any additions as part of the confirmation of the minutes at the next meeting as well as under matters arising. This has been in place throughout 2025/26.
Board Composition	

Requirements of the Corporate Governance Code	How the Health Board Complies
3.1 The Board should have a balance of skills and experience.	The Board comprises executive directors who each have their own portfolios of responsibilities as well as independent members who each have an area of expertise.
3.2 The roles and responsibilities should be clearly defined for Executive directors	These are set out in the scheme of delegation which forms part of standing orders. A review of Executive Team Members portfolios was undertaken in the year.
3.5 Non-executive Board members will exercise their role through influence and advice, supporting as well as challenging.	Independent Members understand their role is one to scrutinise and seek assurance which is undertaken in Board and Committee meetings. They provide advice and guidance on the annual plan and organisational strategy, monitor performance and operational issues as well as participate in the recruitment of Executive Directors.
3.10 The Board should provide collective strategic and operational leadership.	This is discharged through the Board and its Committees (see 2.2)
3.11 The Board should include people with a mix and balance of skills	There are a number of skills and expertise across the Board including medical, nursing, finance, workforce and strategy
3.12 The mix and balance of skills and understanding should be reviewed periodically, at least annually as part of the board effectiveness evaluation.	The Board received a Structured Assessment from Audit Wales in March 2026.
3.13 The search for Board candidates should be conducted on merit with due regard for the benefits of diversity, such as gender.	Public appointments are supported by Welsh Government who request demographic information for Board Members prior to appointment and commencement of role. This was the case for the appointments made in 2025/26.
Board Effectiveness	
4.1 The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively.	There were formal procedures in place in 2025/26 for the appointment of new Board Members and sufficient time was allowed for Members to discharge their duties with provision in the Standing orders for papers to be circulated at least five clear days.

Requirements of the Corporate Governance Code	How the Health Board Complies
4.5 The terms of reference for the nominations committee will include scrutinising systems for identifying and developing leadership, scrutinising succession plans for senior management and scrutinising incentives and rewards.	The Remuneration Committee fulfils this function and is developing plans to monitor and deliver succession planning as well as developing leadership. This is evidenced through the development of the Executive Portfolio that has been led by the Chief Executive during 2025/26 with engagement with the Remuneration Committee and Executive Team As the Health Board is required to adhere to the agenda for change policy which sets out remuneration, incentives and rewards are not applicable as they are not part of the package.
4.6 The attendance record of Board members shall be disclosed in the governance statement.	This is included within the appendices of the DRAFT Accountability report for 2025/26.
4.10 Where necessary, Board members shall seek clarification on board issues or papers through the Board Secretary.	All members have had access to the Director of Corporate Governance who has acted as an advisor to the Board.
4.11 An effective Board Secretary is essential.	Regular agenda planning sessions take place for the Board and Committees and mechanisms were in place during 2025/26 to ensure information flows from these fora to the executive directors and independent members, as well as senior management. The role also provided some advice and support to implement governance arrangements.
4.14 Evaluations of the performance of individual Board members should show whether each continues to contribute effectively.	Regular appraisals are undertaken by the Chair and Chief Executive who are then appraised by Welsh Government. The Chair of the Health Board undertakes reviews with individual Independent Members.
4.15 All potential conflicts of interest for non-executive board members should be considered on a case-by-case basis.	During 2025/26 each Board Member has been asked to submit a declarations of interest form at the start of each year and update it throughout as new conflicts arise. These are scrutinised by the corporate governance function and the Audit Committee as well as recorded in the accountability report. As part of this work each Board member received and confirmed the interests they declared and this

Requirements of the Corporate Governance Code	How the Health Board Complies
	was reviewed and checked through Companies House and Charity Commission records. Records of Board and Committee meetings highlight where there have been case by case interests considered during 2025/26
Risk Management	
5.1 The Board should ensure there are effective arrangements for governance, risk management and internal control.	A risk management framework was agreed in 2025/26 which sets out the organisation's approach, led by the Director of Corporate Governance. Risk Management arrangements are also reviewed annually on the Internal Audit plan and this is reported through the Audit Committee to the Board.
5.2 The Board should take the lead on and oversee the preparation of the governance statement.	A draft is shared with the Audit Committee for comments before the Board approves it for 2025/26.
5.3 The Board's regular agenda should include scrutinising risk management.	The Corporate Risk Register update was provided in every quarter during 2025/26. Updates on the Board Assurance Framework was received twice during 2025/26. In addition to this, the Board had a development session during 2025/26 to develop and approve a risk management appetite for the Health Board. The Audit Committee scrutinises the management of risk in the Health Board and reports to the Board by way of a Chair's Report.
5.4 The key responsibilities of the non-executive board members include forming an audit and risk committee	An Audit Committee has been in place throughout 2025/26 and has had continuity of Chair arrangements.
5.5 The head of internal audit should periodically be invited to attend Board meetings.	The postholder attends the Audit Committee and other Board Committees regularly and Board meetings as necessary.
5.6 The Board should assure itself of the effectiveness of the risk management system and procedures	This is undertaken by the Audit Committee. On 29 January 26 the Board approved the Board Assurance Framework.

Requirements of the Corporate Governance Code	How the Health Board Complies
5.7 The Board should ensure there is appropriate risk management through the teams	This is delegated to the Audit Committee which monitors the full risk register with tailored registers for the other Committees of the Board. The Audit Committee also receives reports with the responsible Executive Lead associated with it.
5.8 The Board should ensure there are effective arrangements for internal audit.	During 2025/26 the Audit Committee received the annual internal audit plan at the start of the year and then the findings of each review undertaken are reported on a standing agenda item. The full reports are then referred to the relevant Board Committee to follow-up the action plans of those which cause concern. The Audit Committee reported to the Board on these matters in 2025/26.
5.9 The Board and accounting officer should be supported by an Audit and Risk Committee.	An Audit Committee has been in place since the inception of the Health Board and throughout 2025/26. It is chaired by the finance Independent Member.
5.10 The Audit and Risk Committee should support the Board by advising on key risks	The Audit Committee received the risk register on a regular basis throughout 2025/26 and raises issues with the Board as part of its report following each meeting. The Committee also receives Corporate and Board Assurance risks that are aligned to its remit.
5.11 An Audit and Risk Committee should not be charged with executive responsibilities or making/endorsing decisions.	Any decisions to be made are done so by the Board on the recommendation of the committee. During the year 2025/26 this was re-clarified with a review of the Audit Committee Terms of Reference that were aligned to the NHS Wales Audit Handbook.
5.12 The Board should ensure that there is adequate support for the Audit and Risk committee, including secretariat.	This has been provided by the Director of Corporate Governance and a dedicated corporate risk team.
5.13 The annual governance statement is published with the resource accounts each year.	In 2025/26 a draft Annual Governance Statement has been published as part of the Audit Committee papers and Board papers as well as the final version, on the Health Board's website.
5.14 The terms of reference for the Audit and Risk Committee should be public	These are on the Health Board's website and have been updated during 2025/26.

Requirements of the Corporate Governance Code	How the Health Board Complies
5.15 All Boards should ensure the scrutiny of governance arrangements, whether at the Board or at one of its Sub-Committees.	This is undertaken through all Board Committees as well as the Board.

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

4.1 There are no matters for escalation.

5 ARGYMHELLION
RECOMMENDATIONS

5.1 The Committee is asked to:

- **NOTE** the compliance with the corporate governance code;
- **SUPPORT** the assessment of compliance against the corporate governance code; and
- **AGREE** to the assessment being reflected in the accountability report.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: Not required
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not required
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not required
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Not required
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Choose an item.	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	Choose an item.	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	Not required
	Do/Yes: ☐	Naddo/No: ☒

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Audit Committee

INTERNAL AUDIT PROGRESS REPORT ANNUAL INTERNAL AUDIT PLAN INCLUDING THE INTERNAL AUDIT MANDATE AND CHARTER 2026/27

Dyddiad y Cyfarfod Date of Meeting	21 April 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dave Harries, Head of Internal Audit, CMIIA Nicola Jones, Deputy Head of Internal Audit, CMIIA
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Approval

**Crynodeb Gweithredol
Executive Summary**

Progress report

The progress report summarises five reviews finalised since the last Committee meeting in February 2026, with the recorded assurance as follows:

- Substantial assurance – one
- Reasonable assurance –two
- Limited assurance – two

The report also provides the status of the 2025/26 Audit Plan.

Final Internal Audit Plan 2026-27 including the Internal Audit Mandate and Charter

The audit plan for 2026-27 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan.

The Plan details the risk based planned audit reviews for 2026/27 following a review of Board and Committee papers, Board Assurance Framework, Corporate Risk Register, meetings with Independent Members and Executive Directors, and reviews deferred from 2025-26.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
CHC	Continuing NHS Healthcare
IRCF	Integrated Regional Care Fund
RAH	Royal Alexandra Hospital
NICE	National Institute for Health and Care Excellence
IA	Internal Audit
SOP	Standard Operating Procedure
DDaT	Digital Data and Technology Directorate

Internal Audit report

1. **Y SEFYLLFA**
SITUATION

1.1 The progress report is required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.5 Reviewing Internal Audit Assignment reports.

1.2 The BCUHB annual INTERNAL audit plan for 2026/27 is required in accordance with section 4.4 of the handbook - reviewing the internal audit plan.

2 **Y CEFNDIR**
BACKGROUND

2.1 The report provides details of audit reports issued as final and the status of the 2025/26 Internal Audit Plan.

2.2 The BCUHB Annual Audit Plan for 2026/27 sets out the planned audits for the year.

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

3.1 Two limited assurance reports have been issued in the period; National Institute for Health Care and Excellence (NICE) Guidance Compliance and On-Call Arrangements.

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

4.1 There are no specific risks other than those relating to individual reviews/findings.

5 **ARGYMHELLION**
RECOMMENDATIONS

5.1 The Committee is asked to:

- Note the findings within the progress report and associated audit reports.
- Approve the internal audit plan, mandate and charter for 2026/27

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 1. Building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Wise Spending Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	N/A other than those relating to individual audit reviews / recommendations.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Equality duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports). The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol? **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Socio-Economic duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports).
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The Armed Forces Covenant Due Regard duty is not applicable. The progress report and plan are required per the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 (Reviewing the Internal Audit Plan) and Section 4.5 (Reviewing internal audit assignment reports).
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	There is no identifying information included in the progress report or reports.
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	Counter Fraud considerations are taken into account for all relevant audit reviews, and for the plan.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Internal Audit Progress Report

Audit Committee

3 February 2026 to 8 April 2026

Betsi Cadwaladr University Health Board

Contents

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

Introduction

This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2025/26.

Reports Issued

Since the last progress report, six reviews have been issued as final.

Table 1: Summary of final reports issued

Review	Assurance rating	Key issues
National Institute for Health and Care Excellence (NICE) guidance compliance (BCU-2526-28)	Limited	The Health Board has significantly reduced overdue NICE guidelines, but limited assurance remains due to gaps in reporting, inconsistent use of compliance tools, reduced Executive oversight, and delays in escalation. Weaknesses in monitoring, justification of overrides, and identifying care delivered beyond NICE guidance limit assurance and may affect value for money.
On-call arrangements (BCU-2526-26)	Limited	The review found limited assurance that on-call arrangements are operating effectively, with key weaknesses including the absence of a finalised policy, inconsistent management of compensatory rest, and uneven access to training and support, which also affects compliance with the Civil Contingencies Act. Although issues remain, staff reported improvements in recent years, and the draft policy and strengthened training represent positive progress.
Statutory Compliance - Asbestos Management (BCU-2526-32)	Substantial	The review received substantial assurance, confirming that the Health Board has strong, well-established systems for managing asbestos, with clear accountability and no significant issues identified. Although the Senior Estates Manager has recently left, interim support is in place, and training compliance has risen to over 85%. Ongoing discussions about asbestos labelling continue, but as this is not a statutory requirement, it does not affect overall assurance
Centre for Mental Health and Society (BCU-2526-44)	Advisory	The review found that the agreement between Bangor University and the Health Board has not been reviewed since inception in 2012, and that undocumented changes have occurred over time. In particular, the number of posts recharged to the Health Board has increased without

		clear justification, driving additional cost; although these were approved in line with the Scheme of Reservation and Delegation, approvals were made individually rather than through an annual "blanket" order arrangement that would have attracted greater scrutiny and approval. The proposed future arrangements do not fully meet the requirements of the latest Welsh Health Circular *NHS framework for research and development*, nor do they consider alternative academic partnerships. The review identified gaps in evidencing compliance with Standing Financial Instructions and concluded that the Health Board cannot demonstrate value for money, with limited evidence of efficiency, effectiveness, or direct benefit to the North Wales population, alongside risks including potential duplicate funding, weaknesses in honorary contract processes, and incomplete declarations of interest for some associated staff. The Health Board and its Charity have made significant financial contributions since its inception, amounting to an estimated £4,292,733 at the time of the review.
Culture and Leadership Development – delivery of priorities (BCU-2526-24)	Reasonable	The review found reasonable assurance that the Health Board is progressing its compassionate leadership priorities, but evidence submitted to the Programme Management Office is incomplete and comprehensive updates on Culture, Leadership and Engagement plans are not consistently provided to the People and Culture Committee. While structured plans exist and regular updates occur, clearer reporting is needed to demonstrate full delivery of IMTP priorities.
Risk Management and Board Assurance Framework (BCU-2526-01)	Reasonable	The review found reasonable assurance over the Health Board's risk management and Board Assurance Framework. While responsibilities and systems (including Datix) are in place and the corporate risk register has been streamlined, several issues need attention: unclear links between risk gaps and actions, 105 overdue reviews within the Operational Leadership Team, overdue reviews in sampled divisional registers including high-rated risks and low uptake (4%) of risk awareness training among staff,

		despite good training compliance for risk owners and Board members.

Image 1: Summary of final report assurance ratings issued as of 8 April 2026

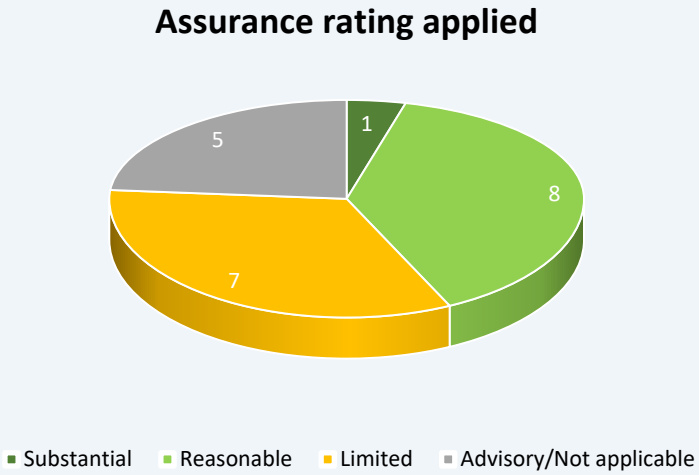


Table 4 details the status of all reviews in the 2025/26 plan.

Follow-up

The Corporate Governance Directorate provides Internal Audit with details of actions agreed as closed by Executives and provide relevant evidence to support closure. We have reviewed seven recommendations relating to capital projects, with the outcomes noted in the table below.

Table 2 – Status of follow-up actions submitted for closure

Recommendation - category by submission	Number of recommendations	Closed	Partially closed	Outstanding
Submitted for first (1st) review	7	4* (57%)	1 (14%)	2 (29%)

*1 closed as a future review is due

Contingency/Health Board support/Advice

Internal Audit supports the Health Board through providing advice and guidance on areas of control, new systems, and processes.

We have met with Audit Wales to discuss recent issues and areas of emerging risks to the Health Board.

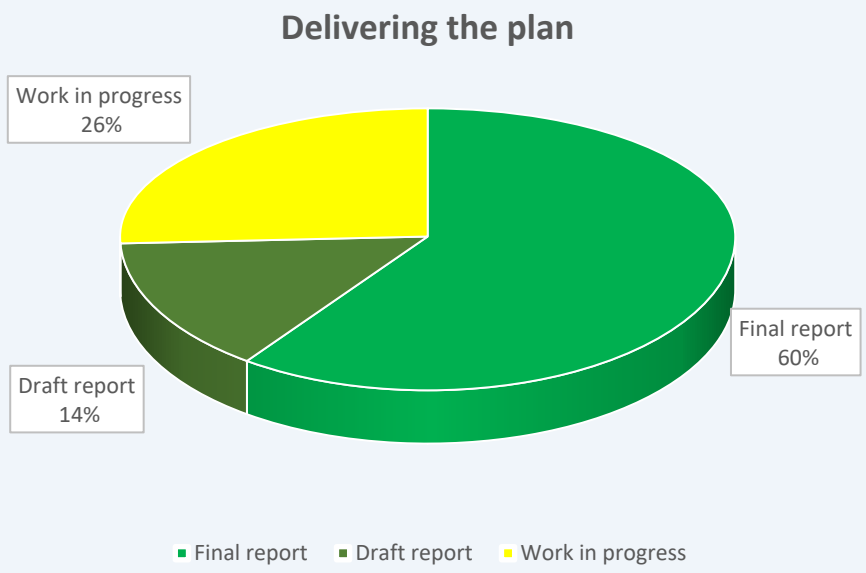
We have attended and observed the Risk Scrutiny and Executive Policy Oversight Groups in this reporting period, coupled with attending/observing the Health Board and its Committees. We also participate in the All-Wales Direct Payments for Continuing NHS Healthcare (CHC) Implementation Task and Finish Group, which the Health Board is leading.

We have met with the Director of Corporate Governance in this reporting period.

Delivering the plan

The status of the 2025/26 internal audit plan is detailed in image 2 (excluding proposed additions to the plan).

Image 2: Status of plan delivery



The additional support provided to the Health Board with focused reviews is channelled through contingency.

As new risks are identified in year, the Director of Corporate Governance and Head of Internal Audit will consider the planned reviews against the emerging high-level risks.

The following tables detail the planned performance indicators (Table 3) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 4).

For 2025/26, twenty-one reports have been issued as final, with eight missing the management response timeline.

Table 3 is reporting a positive status across all indicators including plan delivery and report turnaround time, which has improved from 57% to 62%. Figures are based on reports issued as final.

Table 3: Performance Indicators

Indicator	Status	Actual	Target
Operational Internal Audit Plan agreed for 2025/26		4 March 2025	30 June
Total audit reviews reported against adjusted plan for 2025/26		23	27
Report turnaround: time from fieldwork completion to draft reporting [10 days]		100%	80%

Indicator	Status	Actual	Target
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement]		62%	80%
Report turnaround: time from management response to issue of final report [10 days]		100%	80%

Key : v>20% 10%<v<20% v<10%

Table 4: Core Plan 2025/26

Planned output	Status	Planned Committee Meeting[1]	Assurance rating
1. Risk Management and Board Assurance Framework (Assurance)	Final report.	April 2026	Reasonable
2. Follow up	Complete.	On-going	Assurance Not Applicable
3. Corporate Legislative Compliance - Civil Contingencies Act 2004 (Assurance)	Final report.	October 2025	Limited
4. Standards of Business Conduct (Assurance)	Work in progress.	June 2026	
5. Executive Committee Governance (Assurance)	Work in progress.	June 2026	
6. Public Health: Prevention and Early intervention – Grant funded activity (Assurance)	Final report.	October 2025	Reasonable
7. Value and Sustainability – delivering quality improvements (Assurance)	Final report.	October 2025	Limited
8. Budgetary Control and Financial Reporting (Assurance)	Deferred.		-
9. Budget Setting (All Wales review) (Assurance)	Work in progress.	June 2026	
10. Patient Experience (Assurance)	Final report.	October 2025	Reasonable
11. Learning – Regulatory reporting (Assurance)	Final report.	October 2025	Limited
12. Outpatient Transformation (Assurance)	Deferred.		-
13. Complaints (Assurance)	Final report.	December 2025	Reasonable
14. Skills and Capabilities (Assurance)	Deferred.		-
15. Delivering successful change and benefits realisation (Assurance)	Final report.	December 2025	Reasonable
16. Non-Digital Data and Technology (DDaT) controlled IT (Assurance)	Draft report.	April 2026	Limited

[1] Subject to change

Planned output	Status	Planned Committee Meeting[1]	Assurance rating
17. Community Services (Assurance)	Final report.	December 2025	Reasonable
18. Productivity and Efficiency (Assurance)	Deferred.		-
19. Planned Care Major Change Programme (Assurance)	Draft report.	April 2026	Limited
20. Urgent Emergency Care (Assurance)	Work in progress	June 2026	
21. Primary Dental Care (Assurance)	Deferred.		-
22. Primary Medical Care – Contract Assurance Framework (Assurance)	Final report.	February 2026	Reasonable
23. Workforce Planning (Assurance)	Deferred		-
24. Culture and Leadership Development – Delivery of priorities (Assurance)	Final report.	April 2026	Reasonable
25. Speaking Up Safely (Assurance)	Draft report.	June 2026	Limited
26. On-call arrangements (Assurance)	Final report.	February 2026	Limited
27. Consultant Job Planning follow up	Final report.	October 2025	Assurance not applicable
28. NICE guidance compliance (Assurance)	Final report.	February 2026	Limited
29. Agency utilisation (Assurance)	Deferred.		-
30. Challenged Care services (Assurance)	Work in progress.	June 2026	
31. Estate Management – Estates and Facilities Alerts (Assurance)	Final report.	February 2026	Limited
32. Statutory Compliance: Asbestos Management (Assurance)	Final report.	April 2026	Substantial
33. Capital Systems (Assurance)	Deferred.		-
34. Wrexham Maelor Hospital Engineering Infrastructure Programme (Assurance)	Deferred.		-
35. Integrated Regional Care Fund (IRCF) Projects (Assurance)	Deferred.		-
36. Falls Management follow up	Final report.	August 2025	Assurance not applicable
37. Contract management and procurement – Digital Data and Technology (Advisory)	Final report.	August 2025	Advisory
38. Contract management and procurement – Executive and Director corporate functions (Assurance)	Final report.	December 2025	Limited
39. Adult and Older Persons Mental Health Unit at Ysbyty Glan Clwyd (Assurance)	Deferred.	June 2026	-
40. Pharmacy regulatory compliance	Work in	June 2026	

Planned output	Status	Planned Committee Meeting[1]	Assurance rating
	progress.		
41. Sickness management	Work in progress.	June 2026	
42. Purchase cards & Petty cash	Draft report.	June 2026	Reasonable
43. Capital Governance Arrangements	Draft report.	June 2026	Advisory
44. Centre for Mental Health and Society	Final report.	April 2026	Advisory
45. Integrated Audit Plan – Nuclear Medicine	Work in progress.	TBC	
46. Integrated Audit Plan - Royal Alexandra Hospital (RAH) Health and well-being Hub	Work in progress.	TBC	

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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.

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.

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]

Internal Audit Plan 2026/27

Betsi Cadwaladr University Health Board

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GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership
Audit and Assurance Services

1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Betsi Cadwaladr University Health Board's (BCUHB) management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Three-Year Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the corporate risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies can add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of BCUHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan.
- An assessment of BCUHB's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees.
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with the Chair of the Board and Committee Chairs.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by BCUHB, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately based on a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by BCUHB, in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Dave Harries CMIIA
Pennaeth Archwilio Mewnol/Head of Internal Audit
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2026/27

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
1. Risk Management and Board Assurance Framework To review the effectiveness of Risk Management arrangements across the Health Board, and the efficacy of the Board Assurance Framework in identifying/monitoring strategic risks that will stop the Health Board delivering its strategic objectives.	BAF 24-01	Director of Corporate Governance	Q4
2. Follow up To review the evidence submitted by the Health Board to close audit recommendations resulting from, in the main, Limited Assurance reports and those defined as 'High Risk' in other reviews. This will be reported to the Audit Committee through Audit & Assurance progress reports.	BAF 24-01	Director of Corporate Governance	Q1-4
3. Health & Safety To review compliance with HS01 Occupational Health and Safety Policy, assessing the adequacy of management arrangements for Health & Safety to provide assurance to the Health Board.	BAF 24-01 CRR 25-08 CRR 25-10	Director of Environment and Estates	Q1
4. Foundations for the Future – Project delivery We will review the governance, accountability, decision making and delivery of *Foundations for the Future* in line with the steps taken at Discovery phase through to current state and the reporting arrangements to the Health Board or its Committees.	BAF 24-06 CRR 25-07	Chief Executive/Executive Director of People & OD	Q1

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
5. Foundations for the Future – Operational governance and accountability We will review the design and implementation of governance arrangements to ensure the system of internal control is not lessened, accountability arrangements are clear and the Health Board Scheme of Reservation and Delegation is complied with.	BAF 24-06 CRR 25-07	Director of Corporate Governance	Q3
6. Implementation of Ministerial Directives To assess whether the Health Board has effective systems and controls to receive, interpret, implement, monitor and evidence compliance with ministerial directives issued by Welsh Government.	BAF 24-06 CRR 25-08	Director of Corporate Governance	Q2
7. Integrated Medium Term Plan (IMTP) development and Annual Delivery Plan To review the process undertaken for the development of the IMTP and Annual Delivery Plan including the mechanisms to identify priorities, engagement with stakeholders and alignment to national criteria.	BAF 24-02 CRR 25-05	Interim Executive Director of Transformation & Strategic Planning	Q1
8. Accountability and Performance management To review the implementation of, and confirm that, the Integrated Performance Framework (IPF) 2023-25 is operating as expected.	CRR 25-06	Executive Director of Finance	Q3
9. Value and Sustainability – Project assurance including specific focus on the steps being taken to address clinical variation	BAF 24-03 CRR 25-06	Executive Director of Finance	Q1

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
To review the value and sustainability project governance and assurance arrangements. We will also consider the steps being taken in the Health Board to identify and eliminate unwarranted variations in care, ensuring consistent, evidence-based treatment across the Health Board.			
10. Private Practice To review compliance with the Health Board Private Practice Policy (MD14), which sets out the requirements for doctors undertaking private practice and fee-paying work within NHS and uncontracted time.	BAF 24-03 CRR 25-06	Executive Director of Finance	Q1
11. Budgetary Control & Financial Reporting To review whether the Health Board has effective controls in place to manage its financial budgets, including delegation and information available to budget holders.	BAF 24-03 CRR 25-06	Executive Director of Finance	Q2
12. Delivery of Savings To review the identification and delivery of savings as outlined in the IMTP - Financial Plan for 2026/27.	BAF 24-03 CRR 25-06	Executive Director of Finance	Q2
13. Quality Management System (QMS) We will review project governance/management arrangements, roll-out and use of the QMS within the Health Board.	BAF 24-07 CRR 25-08	Executive Director of Nursing & Midwifery	Q4
14. Clinical Audit Following limited assurance opinions in 2023/24 and 2024/25, we will undertake a full review of Tiers 1, 2 and 3	BAF 24-07 CRR 25-08	Executive Medical Director	Q3

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
clinical audits to ensure they provide assurance to the Health Board.			
15. Medical Devices To review the Health Board's governance and asset management arrangements for medical equipment and devices, assessing whether structures, controls and planning processes effectively ensure that equipment is safe, well maintained and appropriately replaced.	CRR 25-08	Executive Director of Allied Health Professionals and Health Science	Q3
16. Commissioned Services – Specification & Performance To review development of the service specification for commissioned services through to performance management of a sample of contracts.	BAF 24-07	Executive Director of Finance	Q2
17. Research & Development To review the Health Board's compliance against Welsh Health Circular (WHC/2023/026) *NHS Framework for Research and Development – Research Matters – What excellence looks like in NHS Wales*. We will also review compliance with the Health Boards Scheme of Reservation and Delegation and documented procedures.	BAF 24-08	Executive Medical Director	Q2
18. Suicide prevention – *The Suicide Prevention and Self-harm Delivery Plan for Wales 2025-2028* We will identify the steps being taken in the Health Board to support the implementation of the Welsh Government prevention and self-harm delivery plan and how this is reported through for assurance.	BAF 24-06	Executive Director of Allied Health Professionals and Health Science	Q1

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
19. Skills and Capabilities To review whether the required skills and capabilities for delivering and managing digital transformation across the organisation are identified and plans are in place to ensure they are brought into the organisation.	BAF 24-02 CRR 25-02	Chief Digital and Information Officer	Q2
20. Cyber Security To review how the Health Board is working to improve its cyber security position, and the processes in place for monitoring compliance and providing assurance that the risks are appropriately stated and in line with the risk appetite.	BAF 24-02 CRR 25-11	Chief Digital and Information Officer	Q1
21. Service management (ITIL) To review how the Health Board ensures that digital services and support are provided in an efficient manner which reflect the needs of the organisation and that changes are managed appropriately.	BAF 24-02 CRR 25-04	Chief Digital and Information Officer	Q3
22. Artificial Intelligence (AI) - Governance and Control To review how the Health Board is developing and delivering a governance structure around the use of AI to ensure that the benefits are maximised whilst protecting the security and integrity of information.	BAF 24-02 CRR 25-04	Chief Digital and Information Officer	Q4
23. Planned Care Delivery - Validation To review the Health Board's compliance with Policy PC02 Clinical Validation Policy for the Management of Planned Care Waiting Lists and PC03 Clinical Validation Procedure for the Management of Planned Care Waiting Lists.	BAF 24-07 CRR 25-01	Chief Operating Officer	Q3

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
24. Urgent & Emergency Care (UEC) – Verifying UEC Flow To review compliance with the Operational standards - UEC flow as issued on 5 December 2025 to the Hospital Management Teams and IHC Senior Leadership Teams.	BAF 24-07 CRR 25-01	Chief Operating Officer	Q3
25. Funded Nursing & Continuing Health Care To review and ensure the Health Board is complying with Continuing NHS Healthcare - The National Framework for Implementation in Wales and its own associated governance documents.	CRR 25-03	Chief Operating Officer	Q3
26. Primary Dental Care To review the arrangements in place for the management of primary dental care contracts and Health Board delivered services, to ensure timely and equal access to healthcare.	BAF 24-06 CRR 25-03	Chief Operating Officer	Q4
27. Violence and Aggression To assess the adequacy and effectiveness of arrangements for reporting, investigating and responding to violent or aggressive incidents involving staff. This will include an examination of Datix reporting completeness and timeliness, evaluation of staff support processes, and consideration of preventative and protective controls such as security provision and CCTV coverage. We will also consider the steps taken by the Health Board to implement Sections 119 and 120 of the Criminal Justice and Immigration Act 2008 that came into force in Wales on 16 January 2026 - *Managing nuisance behaviour on NHS Wales premises*.	CRR 25-10	Director of Environment and Estates	Q2

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
28. Culture To assess whether the Health Board has effective governance, systems, and behaviours that support a positive, safe, and values-driven organisational culture.	BAF 24-04		Q2
29. Statutory Compliance: Water Safety To review compliance with *Welsh Health Technical Memorandum 04-01 Safe water in healthcare premises Part B: Operational management* and associated Health Board Policy/operational procedure.	BAF 24-03 CRR 25-09	Director of Environment and Estates	Q4
30. Management of leases To assess whether the Health Board has effective governance, controls, and processes to manage leases (leased-in and leased-out) in compliance with financial, legal, and regulatory requirements.	CRR 25-06	Director of Environment and Estates	Q4
31. Space utilisation (Advisory) To determine the adequacy of, and operational compliance with, established systems for the management, control and utilisation of space within the Health Board, and will also take account of other supporting regulatory and procedural requirements, as appropriate.	CRR 25-09	Director of Environment and Estates/Chief Operating Officer	Q2
32. Capital Systems Acknowledging the Health Board's £21.9m Target Estates Funding (TEF) allocations provided by Welsh Government during 2025-27, we will seek to obtain assurance that appropriate controls are applied, and capital systems operate	BAF 24-03 CRR 25-09	Director of Environment and Estates	TBC as projects progress through stages of approval

Planned output, Outline scope, Review reference	Strategic Intent (SI)/BAF Risk / Corporate Risk Register (CRR) Risk/ Rationale	Executive Lead/Responsible Director	Planned start
effectively in the allocation and delivery of the allocated funds.			
33. Integrated Audit & Assurance Plans The Internal Audit Plan will be supplemented through the year by major project/programme audits agreed through the respective SOC/OBC/FBC/BJC funding provisions approved by Welsh Government.	BAF 24-03 CRR 25-09	Director of Environment and Estates	TBC as projects progress through stages of approval

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft by 30 April	⚑	To deliver plan
Audit opinion 2025/26 delivered by 31 May	⚑	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	⚑	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	⚑	80%
Report turnaround management response to draft report [20 working days maximum]	⚑	80%
Report turnaround draft response to final reporting [10 working days]	⚑	80%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Betsi Cadwaladr University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Betsi Cadwaladr University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Betsi Cadwaladr University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
- the appropriate assessment and management of risk, and the related system of assurance.
- the arrangements to monitor performance and secure value for money in the use of resources.
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, and the Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee which of these they want

reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned.
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register.
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
- reviewing the Annual Governance Statement prepared by senior management.

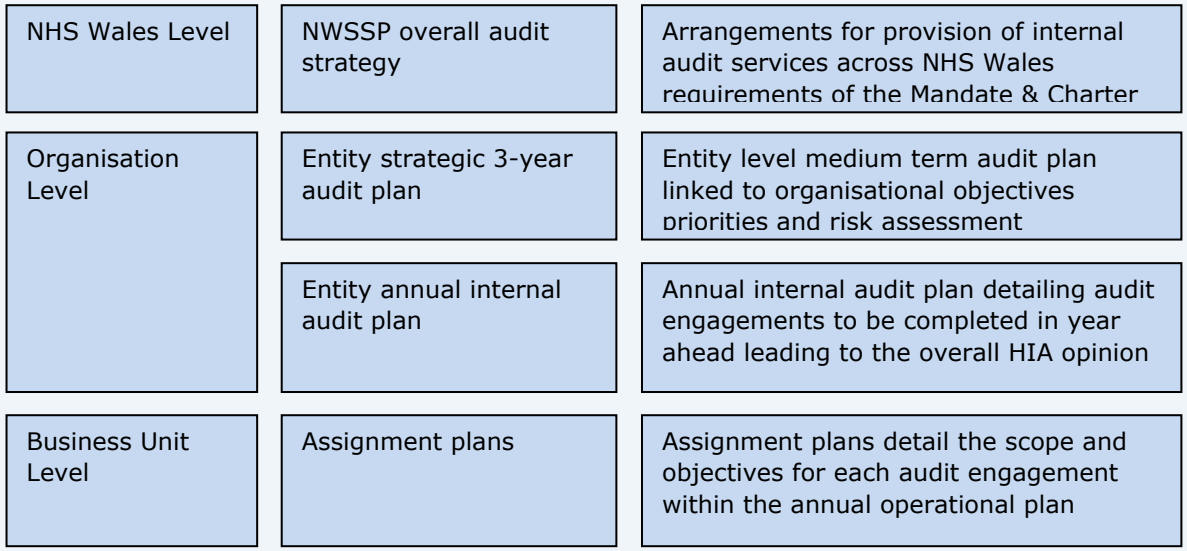
7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy



8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
  b) Disclose any qualification to that opinion, together with the reasons for the qualification.
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual

Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Global Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 20 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where no

management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
February 2026

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 Mandate and 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 regarding the advice and information contained.

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

Global Internal Audit Standards

Audit 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. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Archwilio Cymru
Audit Wales

Betsi Cadwaladr University Health Board – Audit Committee Update

Date issued: April 2026

Contents

This document has been prepared as part of work performed in accordance with statutory functions.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Introduction

This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Betsi Cadwaladr University Health Board (the Health Board). We are presenting our Audit Plan to the committee in April 2026.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Planning work ongoing
- **Expected committee date:** 23rd June 2026

Audit of the 2025-26 Awyr Las Accounts

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2025-26 Audit of Awyr Las Annual Report and Accounts.
- **Status:** Planning work ongoing
- **Expected committee date:** January 2027

Performance audit update

Structured assessment 2025 – core

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment reviewed:
  - Board and committee cohesion and effectiveness;
  - Corporate systems of assurance;
  - Corporate planning arrangements; and
  - Corporate financial planning and management arrangements.
- **Status:** Complete
- **Expected committee date:** April 2026

Use of the strategic financial assistance provided by the Welsh Government for the period October 2020 onwards

- **Executive Lead:** Executive Director of Finance
- **Focus of the work:** This audit will encompass a high-level examination of the Health Board's arrangements for using the additional £297m financial assistance provided by the Welsh Government as part of the targeted intervention package announced in October 2020.
- **Status:** In clearance discussions with the Health Board.
- **Expected committee date:** April 2026

Review of quality governance arrangements

- **Executive Leads:** Executive Director of Nursing, Executive Medical Director and the Executive Director of Allied Health Professionals and Health Science.
- **Focus of the work:** This audit will examine progress in addressing issues identified in previous audit work. The scope of the work will be determined during the audit planning process.
- **Status:** In clearance discussions with the Health Board.

Expected committee date: June 2026

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Drafting
- **Expected committee date:** June 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Chief Executive Officer
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Fieldwork in progress
- **Expected committee date:** August 2026

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider:
  - The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
  - The efficacy of local plans and associated actions to recover cancer waiting lists; and
  - Use of the additional Welsh Government financial allocations to improve cancer services.
- **Status:** Planning
- **Expected committee date:** August 2026

Other relevant publications

Over the past three months, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

Additional Learning Needs: Do public bodies know if the system is working?	April 2026
Managing the Regional Integration Fund	March 2026
Checking the patients. Results from a pilot data matching exercise on GP patient lists	January 2026

Since the last committee update, Audit Wales has not published any new corporate documents.

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Structured Assessment 2025

Betsi Cadwaladr University Health Board

March 2026

About us

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

If you need any help with this document

If you would like more information, or you need any of our publications in an alternative format or language, please:

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Corresponding in Welsh will not lead to a delay.

Mae’r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot

What we looked at

1 We looked at how well Betsi Cadwaladr University Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:

- how well its board works;
- how it keeps track of risks, performance, service quality, and recommendations;
- how it produces key plans and strategies; and
- how it manages its finances.

2 We also looked at the Health Board's progress in implementing recommendations from:

- previous structured assessment reports; and
- our 2024 report on cost savings.

Why this is important

3 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

4 We found that the Board and its committees are operating effectively with open discussion and effective challenge. However, executive leadership arrangements are causing some concern. Despite there being a largely substantive Executive Team in place, the Chief Executive is still being drawn too extensively into operational issues and specific programme leadership. There is also a need to ensure executive portfolios support more collective organisational leadership by the Executive Team rather than this being vested in just a few individuals.

5 The Health Board's current operating model is recognised as not being fit for purpose. Much stronger and clearer accountabilities for performance is needed given the significant service delivery challenges being faced by the organisation. The Foundations for the Future programme that aims to introduce a new operating model is a necessary and appropriately ambitious initiative. However, its implementation is taking longer than originally planned. The revised implementation date of April 2026 looks very challenging given that limited and high-level information on the model has shared with the Board. The model will also require an extensive internal consultation exercise before it can be rolled out.

6 The Health Board is focusing strongly on the achievement of its statutory financial requirements. It is encouraging that it was able to submit a financially balanced medium-term plan, although the plan was not approvable due to a lack of detail on delivery approaches. A focus on longer term financial sustainability is still needed, although this is being impeded by the continued absence of a clinical services plan.

7 There is good oversight of financial performance but the Health Board is forecasting a year-end deficit position of £17.4 million as of month ten. It is also of significant concern that a number of accountability agreements for 2025-26 were signed very late into the 2025-26 financial year, including by several of budget holders in the Executive Team.

What we recommend

8 We have made nine recommendations to the Health Board within the following areas:

- Increasing transparency within board business;
- Strengthening lines of assurance to board committees;
- Strengthening resilience within the Executive Team;
- Ensuring financial controls are well-understood, clearly articulated and agreed; and
- Ensuring sufficient programme management capacity for its review of operating structures.

Key facts and figures

Within the Welsh Government's Escalation and Intervention framework, the Health Board is currently at level 5 (Special Measures).

In 2024-25, the Health Board had a year-end deficit of £7.6 million.

In 2024-25, the Health Board aimed to save £48 million but ended up saving £58.4 million.

The Health Board's 2024-25 financial statements were submitted for external audit on time. The accounts received an unqualified True and Fair opinion. However, they also received a qualified regulatory opinion because the Health Board did not break even from 2022–23 to 2024–25.

Despite submitting a financially-balanced Integrated Medium Term Plan for the first time in 13 years, the plan was not approved by Welsh Government due to a failure to set out how the Health Board would meet Welsh Government delivery expectations in a number of key areas.

The Health Board is facing significant in-year financial challenges, and, as of month-ten is projecting a deficit of £17.4 million for 2025-26.

The Health Board has fully implemented 11 out of 19 outstanding structured assessment recommendations since our last report.

Our findings

Board effectiveness and executive leadership

The Board and its committees operate well. With most executive team roles now filled substantively, it is crucial that responsibilities are more effectively delegated and distributed amongst that team

Public openness of board business

9 The Board runs its meetings in an open and accessible way. Most meetings take place in person in Llandudno, with extra meetings held online. Live translation from Welsh to English is available. The public can join meetings by attending in person or watching them on YouTube, either live or as a recording. Board members speak openly and do not avoid discussing difficult topics.

10 The Health Board has made it easier for the public to access information about its committees. The website explains how people can ask to attend its public committee meetings which are mostly held in person. Unlike Board meetings, they are not live-streamed but are recorded for the purposes of the minutes. The Health Board is considering ways to increase the public transparency of meetings in accordance with its Standing Orders.

11 In general, private sessions of Board and committee meetings are handled appropriately. Papers explaining why items are kept private are mostly provided, but in very few instances this information is missing. The Health Board should make sure this is always included. Some of those we interviewed also suggested that authors could more carefully separate sensitive and non-sensitive information to put more information in the public domain.

12 There has been a small increase in the number of decisions taken as chair's actions[1] in 2025 although the Health Board is managing these appropriately. The Health Board states this is a result of additional requests coming through that could not have been reasonably foreseen before a formal meeting. Most reports of chair's actions over the past 12 months clearly demonstrated how they were supported by Independent Members, and actions were well-documented, including the financial implications of decisions, though we note the report for November 2025 did not include this detail as this was commercially sensitive due to an individual claim.

13 Papers to support Board and committees are generally published in a timely way and in accordance with Standing Orders. Breaches in respect of late papers are reported to the Audit Committee although members have raised concerns at Audit Committee during the year that not all breaches are captured on the breach log.

14 The Health Board publishes committee meeting minutes after they have been confirmed at the following committee meeting, which is typically two or three months later. The Health Board introduced "Alert, Assure, Advise" highlight reports in December 2024. These are provided within Board agenda packs and effectively summarise the key committee decisions and discussion points to help provide assurance to the Board. If the Health Board is not able to publish minutes in a more timely way, it should look to upload the Alert, Assure, Advise reports to the website in advance of the Board papers as an alternative measure.

[1] A 'chair's action' refers to a decision taken outside of a formal board or committee session.

Supporting effective board conduct

15 The Health Board is working to improve its processes for recording declarations of interests, gifts and hospitality. An internal audit into standards of business conduct in 2023-24 provided a limited assurance rating in this area. Their subsequent follow up found that while some progress had been made, many actions were overdue. These included strengthening approval processes and the accuracy of published Board Member Register of Interests. The Health Board is working to address these issues by March 2026.

16 The Health Board is updating its overdue policies, however, progress is slow. Although action was taken to improve the position in 2024, by October 2025 38% (40 out of 104) of its total policies remained overdue. Of these only seven out of 18 high-risk policies have been updated in the last six months. It is therefore important that the revisions the Health Board is currently making to its policy management process support more timely review.

Assurance on Joint Commissioning Committee effectiveness

17 The Joint Commissioning Committee (JCC) was established in April 2024 as a joint committee of the seven Health Boards in Wales. It is responsible for planning and commissioning a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven Health Boards.

18 As part of this year's structured assessment, we reviewed whether the Board is receiving the right level of assurance about how effectively the JCC is operating, as well as about the Health Board's involvement in JCC meetings and activities.

19 The Board has received some information related to the activity of the JCC during the past 12 months. This has included two quality safety outcomes highlight reports from the JCC to the Quality, Safety and Experience Committee and changes to the JCC standing orders. However, a consistent theme of our interviews was that Board members did not feel sufficiently sighted on the activity of the JCC and the Health Board's involvement. To strengthen oversight further and ensure the Board feels better informed, the Health Board could routinely share the minutes of the JCC minutes with the Board.

Board and committee meeting effectiveness

20 Our committee observations during 2025 have found that committees are generally working well. Meetings are well-chaired and members observe meeting etiquette and provide a good balance between scrutiny and support. However, particularly during Audit Committee meetings we have noted that the lead Executive Directors are not always in attendance to cover what are sometimes key issues identified in papers and reports, specifically audit reports such as our planned care and urgent and emergency care reports. Discussions at committees would be strengthened by ensuring more consistent representation from appropriate members of the Executive Team for these key items.

21 Each year committees review their terms of reference and cycles of business to ensure their agendas are aligned to the Health Board's key priorities as set out in the IMTP. We have noted however that committee chairs had not been meeting regularly as a group in 2025 due to capacity challenges. It is important that these meetings happen regularly to enable timely cross-referral of issues between committees and triangulation of key risks. We understand these capacity challenges have now been resolved with meetings due to resume in early 2026.

22 The Corporate Governance team is taking action to improve the quality of Board and committee papers. We found that papers sometimes focus on describing activity, rather than explaining performance outcomes and providing realistic trajectories for improvement. The Health Board has s issued a new template for papers and is training report authors in 2026.

Hearing from staff and service users

23 The Board and committees appropriately hear from patients and staff through formal reports and stories which help to set the tone for the subsequent discussions. The Board receives an item at each meeting which contains the experience of either a patient or carer. Recently, the Health Board has aligned its patient experience story to a Board agenda item, such as for urgent and emergency care, which helps it to triangulate information.

24 Members of the Board take part in visits to hear experiences directly from staff and patients. To further strengthen this, in November 2025, the Health Board developed a formal protocol to support the Board when visiting different services across the organisation.

Board cohesion and continuous improvement

25 The Board is now stable in respect of its membership. There has only been one change to the Independent Member cadre with one member leaving in August 2025 and another starting in October 2025. The tenure of the Vice-chair has been extended to November 2026.

26 The Health Board has a valued Board development programme in place. The bi-monthly development sessions were developed by board members and are supported by external facilitators. These development sessions alternate with bi-monthly board briefings on topical issues such as clinical services planning and performance reporting.

27 The Board regularly reflects on the effectiveness of its meetings. Its most recent self-assessment had a good response rate and identified what's working well and where improvements are needed. Members gave positive feedback about the level of interaction and challenge in meetings. They also suggested areas for improvement, including clarifying the role of associate members, shortening papers, and focusing more on strategic issues rather than operational detail.

28 Committees carried out their own self-assessments, which raised similar themes. These exercises show a mature approach and a shared commitment to continuous improvement. Alongside the annual reviews, informal reflection on meetings is a regular item on Board and committee agendas.

Executive Leadership

29 In last year's Structured Assessment, we commented on the need to substantively fill Executive Team vacancies. Over the last year, the Health Board has successfully appointed to three vacant Executive roles,[2] leaving one interim post.[3] This represents a significant step forward in terms of establishing a stable and substantive Executive Team.

30 While the issues we described within the Executive Team in our original Board Effectiveness review in February 2023 are no longer present, the Executive Team is still not functioning in the way it needs to. A clear concern that emerged from our work this year is that the Chief Executive is being drawn into operational issues and programme leadership in a way that places significant pressure on their capacity and affects the pace at which important developments can move forward. This is not a sustainable position in the context of the nature and scale of the challenges the Health Board faces. The Health Board needs to urgently move to a position where the Chief Executive can operate at a higher level, with members of the Executive Team being held accountable for leading their portfolios in line with their delegated authorities.

[2] These are a substantive Chief Operating Officer, who began in April 2025, a substantive Medical Director, who began in October 2025 and more recently a substantive Director of People and Organisational Development, due to begin in early 2026

[3] Executive Director Transformation and Strategic Planning was held by an interim postholder with that term due to end in December 2026 at the time of our review

31 Linked to the above point, it is important that Executive portfolios are realistic and deliverable and do not result in the responsibility for leadership of some of the organisation's most significant challenges being vested in just a few senior leaders. One area that will need to be kept in view is the viability of the portfolio of the Executive Director of Finance. This has recently been expanded to include responsibilities previously held within the Director of Performance and Commissioning role. The Executive Director of Finance also has responsibilities as the "Delivery Director" for Planned Care, which involves providing oversight and assurance of the delivery programme design and implementation. This is alongside the Chief Operating Officer who is responsible for day to day operational deployment to deliver the planned care programme.

32 With the Health Board still in Level 5 escalation and facing significant service delivery challenges it is essential that organisational leadership responsibilities are shared appropriately across the Executive Team such that it can provide the collective and collegiate leadership the organisation requires. This should include a process to identify a designated Deputy Chief Executive.

33 The Health Board set up the new Executive Committee to replace its earlier Executive Team meetings in January 2025. Meetings are well-attended and there is a clear record of the key discussion points and decisions. The Executive Committee reports into the Board, which enhances the transparency of senior decision-making. Whilst this work is positive, there is a need to clarify and formalise the arrangements for the sub-structures that sit underneath and report into the Executive Committee. There is also a need to ensure that the Executive Committee is fully aware of, and able to influence key organisational developments such as the Foundations for the Future Programme. It does not appear that this programme has been discussed at the Executive Committee, despite its central importance in organisational transformation.

Providing board assurance

Despite significant activity to review assurance frameworks, they are not currently resulting in the reduction of risk scores or improving performance

Managing strategic and corporate risks

34 A new, more robust Board Assurance Framework (BAF) is now in place aligned to the Health Board's five strategic priorities. The risks listed on the BAF provide generally good coverage of key risk areas. In addition, the Board discussed and agreed its risk appetite against its strategic objectives during summer 2025. However, as stated in previous years, there is more work to do to ensure that the Health Board's strategic objectives are Specific, Measurable, Achievable, Relevant and Time-bound (SMART). The Health Board will have an opportunity to strengthen this as it moves to revise its long-term vision in 2026.

35 There is regular operational and corporate oversight of BAF risks by management. Risks are also reported to and receive scrutiny from each committee and the Board on a regular basis. Whilst Internal Audit recently provided a reasonable assurance review of risk management, it set out several issues, such as overdue reviews and lack of SMART action planning.

36 Revisions to the corporate risk register encourage a greater strategic oversight of risks, but the Health Board needs to keep this in view to ensure it is now not too high-level to support effective corporate scrutiny and oversight. The revised draft Corporate Risk Register compromises of 11 strategic risks with a selection of the more operational corporate risks de-escalated to be managed operationally at Director level. Discussion at the Audit Committee showed that management need to do further work to ensure risks are defined clearly. At present the corporate risk register is at such a high level that it may lead to risks being interpreted differently. In addition, whilst reports consistently demonstrate actions to address risks, very few risk scores move during the year, suggesting a need to better focus on the impact of mitigating actions.

Managing performance

37 The Health Board's performance framework is not yet sufficiently driving required performance improvements. The Health Board has recently commissioned work to develop a more targeted Performance Management Framework. Its aim is to strengthen performance scrutiny by the Board and its committees by ensuring that metrics are sufficiently and clearly defined. We note improvements to the Health Board's Integrated Performance Report in December 2025 which provides greater analysis of the impact of its improvement activities for areas where performance is off-track.

38 Internal Audit reviewed the current performance framework in July 2025 and gave it a limited assurance rating. A key weakness identified was that there were no written records from performance meetings between operational services and the executive team. This makes it hard to be sure that poor performance is being properly managed. Several of our interviews indicated issues with unclear and weak accountability arrangements, including lack of regular performance management meetings within directorates. The Health Board has set out actions to respond to the weaknesses identified by Internal Audit in this area.

39 Although the Board and its committees regularly scrutinise service delivery, performance against several key targets remains poor or is deteriorating. This is resulting in growing frustration within the Board and increasing concern from the Welsh Government. While there are some notable improvements, such as in complaint responses and a reduction in 104-week Referral to Treatment waiting times and 52-week first outpatient waiting times, performance in other key areas remains worrying. This includes wider planned care performance and associated waiting list accuracy, urgent and emergency care, cancer, primary care, dentistry, and child and adolescent mental health.

40 Reflecting the Health Board's on-going challenges with the delivery of safe, timely and effective care, in November 2025 the Cabinet Secretary for Health and Social Care announced further measures to support the organisation in tackling these challenges. The support will take the form of a small team of experts who will work alongside the Chief Executive and the Board to drive rapid improvements across a number of key service areas.

Monitoring quality and safety

41 We are currently undertaking a review of the Health Board's quality governance arrangements. This work includes a follow-up of actions to respond to recommendations we made in our 2022 Review of Quality Governance Arrangements. This work also incorporates a review of the steps being taken by the Health Board to implement the new Duty of Quality and Duty of Candour under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. We will report this work in early 2026.

Tracking and monitoring recommendations

42 The Health Board is working to improve its approach for responding to recommendations, but there is more to do. The Audit Committee receives the audit tracker at each meeting through its standing Statutory Compliance Report. This includes detail on open audit recommendations and those proposed for closure. Reports also provide information relating to broader regulatory reviews and inspection.

43 Over the course of the year, we have noted positive developments, including a reasonably systematic approach for administering the recommendation database. The Health Board intends to automate this further next year, with a new digital system in 2026. This will automate the process for sending reminders and tracking overdue recommendations. Notwithstanding the broader issues we identify in paragraph 20 around Executive officer attendance at committees, the Health Board has introduced a good process whereby Executive Leads attend the Audit Committee on a rotational basis to discuss their outstanding audit recommendations.

44 Less positively, we have noted persistent issues with delays and incompleteness in management responses to audit recommendations. In some cases, this has then resulted in consequent delays in reporting to committee. We also found that since May 2025 there have been 60 occasions where the evidence to close internal and external audit recommendations was not sufficient. We note that this has recently started to improve. As part of this year's work, we have reviewed the Health Board's progress on previous structured assessment recommendations that are still open. As shown in **Appendix 2**, only 11 out of 19 recommendations made between 2022 and 2024 are now closed, while others are still in progress.

Preparing plans and organisational change

Progress to develop plans and implement change is slower than intended.

Producing key strategies and plans

45 Development of the Health Board's long-term strategy and clinical services plan is taking longer than intended. It originally expected to have both plans in place by September 2025. The Health Board approved a high-level strategic vision statement and set of four strategic intent statements at its January 2026 Board meeting. The Health Board intends these statements to provide a clear direction as it moves forward to refresh its long-term strategy. Whilst work continues to refresh its long-term strategy, the Health Board is continuing to work towards the five strategic objectives[4] it set out in 2023, which have guided its recent planning and risk management work.

46 The Health Board is now aiming to be in a position to seek feedback on a draft clinical services plan by April 2026. Although things are moving more slowly than planned, it will at least enable recently appointed members of the Executive Team, including the Chief Operating Officer and Executive Medical Director to contribute to its development.

[4] The five strategic objectives are: Building an effective organisation; Developing strategy and long-lasting change; Creating compassionate culture, leadership and engagement; Improving quality, outcomes and experience; and establishing an effective environment for learning.

47 The Health Board reviewed and updated its well-being objectives in 2025. As part of this process, it engaged with key external stakeholders, including Welsh Government and the Office of the Future Generations Commissioner, and sought views from staff and the public through a survey. Following this work, the Health Board amended three of its existing objectives and introduced two new ones to reflect recent Welsh Government legislation. Looking ahead, the Health Board plans to undertake a further review of its well-being objectives once its long-term organisational strategy has been updated, to ensure that the objectives remain aligned with any revised strategic priorities.

48 The Health Board submitted a financially balanced Integrated Medium-Term Plan (IMTP) for 2025-28. This is the first financially balanced plan it has submitted since 2012-2013. The Welsh Government recognised this progress but remained unable to approve the plan due to other weaknesses. These included insufficient information on how the Health Board would meet Welsh Government delivery requirements in a number of key areas, including planned care, cancer, diagnostics, urgent & emergency care, diabetes, stroke, dentistry, and Child and Adolescent Mental Health services. Our own review also found that the plan could be strengthened by including information on the internal and external engagement involved in its development.

49 The Health Board is improving how it involves Independent Members in developing its IMTP, but more work is needed. Members saw a draft earlier than in previous years (December 2024 and February 2025), which is positive. However, early drafts had gaps that made review difficult. The Board plans to improve engagement for 2026-27 by discussing IMTP themes during the plan’s development, making the process more inclusive. It also needs to involve operational staff more closely, especially those in its Integrated Health Community (IHC) structure, as well as its regional partners.

Organisational change

50 The Health Board recognises that its current organisational structure and operating model is not supporting clear and effective accountability for the service improvements which are necessary. A need for clearer roles, authority and accountability mechanisms was a common concern raised by the staff we interviewed as part of this year's structured assessment.

51 In response to these challenges the Health Board has established a 'Foundations for the Future' programme. This ambitious programme aims to drive organisational improvements by clarifying staff roles and updating structures, culture, strategy, people, and processes. Whilst the programme is progressing, it is taking longer than originally planned. The Health Board originally intended to finish the design phase of the organisational structure by April 2025 before beginning to put a new structure into action. Plans were then made to share the new structure with the People and Culture Committee in November 2025, but this did not happen either. In January 2026 the Health Board discussed a paper setting out the results of the discovery work on the Health Board's structures. It subsequently agreed that the Health Board could move to the next stage of 'delivery' including engagement and consultation on the new proposed structures.

52 Despite these delays, the Health Board still intends to roll out the new operating model during April 2026, with the People and Culture Committee expecting to receive a draft structure for review in January 2026. However, timescale for roll out is very challenging given the limited capacity within the programme implementation team and the need for significant consultation and engagement with staff across the Health Board ahead of the roll out. Within this timetable, the Health Board will also need to ensure that Independent Members have sufficient time to consider and scrutinise the planned changes. Thus far, there has been limited, and high-level information to the Board at formal and board development sessions.

53 The Foundations for the Future programme was initiated in 2024. Since that time a number of key posts in the current IHC structure have been maintained on an interim basis with other posts remaining vacant. Whilst it is understood that the Health Board will not want to recruit substantively to a structure that is going to change, the current situation is leading to uncertainty for staff and gaps in IHC leadership. Ensuring that there is sufficient capacity to quickly progress the Foundations for the Future programme needs to be a key priority for the Health Board, noting that the changes that the programme will instigate will take time to embed.

54 The Health Board has been progressing its Foundations for the Future programme without a substantive Executive Director of Workforce and Organisational Development in post. The Health Board has, however, now been able to recruit to that post and the successful candidate will take up the role at the end of February 2026 bringing much needed executive capacity to support roll out and implementation of the programme.

Board assurance on partnership working

55 The Health Board is working closely with key partners to deliver shared priorities through the Regional Partnership Board, Public Service Boards and the Six Goals Programme. It also engages directly with key stakeholders including Local Authorities, the Welsh Ambulance Services University NHS Trust and third sector organisations, as well as citizen voice body, Llais. Engagement is used to discuss key priorities and strategic aims, including its winter plans, urgent and emergency care plans and in developing the Well North Wales initiative[5].

[5] https://bevancommission.org/tackling-inequalities-together/

56 Whilst reports to the Planning, Population Health and Partnerships Committee do highlight key activities for specific engagement work, such as on winter planning, the Health Board could improve how it reports on collaborative working. An Internal Audit in August 2025 recognised steps that the Health Board is taking to improve engagement and communication but overall gave a limited assurance opinion. Issues included missed deadlines, unclear evidence of completed actions, no Standard Operating Procedures for engagement, and no reporting on the engagement strategy between January 2024 and March 2025.

Monitoring delivery of strategies/plans

57 IMTP progress reports show the Health Board is doing fairly well with its planned actions. In 2024-25, the Health Board completed 85% of its IMTP actions (268 out of 314). For the 46 actions that were not finished, the Board agreed to either carry them forward into 2025-26 or retire them.

58 However, recent changes to how IMTP progress reports are presented have made it more difficult for the Board to track progress and see how actions are affecting the organisation's performance. An Annual Delivery Plan accompanies the IMTP to provide more detailed milestones to the achievement of plans. The Board received a quarterly progress report in September 2025, and the Performance, Finance and Information Governance Committee received one in December 2025. Changes to the reporting style since September 2025 mean it is no longer clear which actions have been completed in each quarter as reports focus only on whether the Health Board is confident that actions will be completed in-year, and do not show what impact actions may or may not have had on their intended outcomes.

Managing finances

Whilst the Health Board is maintaining a strong focus on achieving in financial balance, significant challenges remain in respect of financial planning and budget management

Meeting financial objectives and duties

59 The Health Board has been in receipt of strategic assistance funding from Welsh Government since November 2020, which includes £40 million a year to support the achievement of year-end financial balance. Despite receiving an extra £11.5 million from Welsh Government on top of its strategic assistance funding, at the end of 2024-25 the Health Board reported a deficit of £7.6 million. To put this in context though, the deficit was equivalent to 0.4% of the Health Board's total operational expenditure and was within the financial control total of £8.6 million set by Welsh Government.

60 The Health Board also failed to meet its statutory duty to break even over the three-year period from 2022 to 2025 with a total deficit of £31.52 million. More positively, the Health Board was able to submit a financially balanced IMTP for the period 2025-28. However, the Welsh Government was not able to approve the plan for the reasons set out in paragraph 49.

61 The Health Board was forecasting reaching a financial balance at the end 2025-26 until month nine. This was despite financial reports showing challenging in-year financial positions. However, the most recent (month 10) position forecasting a £17.4 million deficit with financial reporting highlighting risks of £26 million relating to English Tariff Inflation and the Employers National Insurance funding shortfall, as well as pressures from mental health out of area placements and continuing healthcare.

62 The Health Board has a reasonably good track-record on delivery of savings. In 2024–25, the financial plan required £48 million in recurring savings. By year-end, the Health Board delivered £58.4 million, £10 million more than planned. However, £14.4 million of this was non-recurrent and included “accountancy gains”.

Financial planning arrangements

63 The Performance, Finance and Information Governance Committee received and discussed the Health Board’s financial plan prior to its submission to the Board with the broader IMTP in March 2025. However, the financial plan was focussed on 2025-26, with only limited, and high-level detail on its financial plans for years two and three. This short-term focus does not adequately support the Health Board to make strategic and transformational decisions for its services.

64 The Health Board’s current budget-setting approach does not support longer-term planning for service improvement. In 2025-26, as in previous years, the Health Board has rolled over previous years’ budgets. This approach limits targeted investment in areas that need improvement. The problem is made worse by unfunded permanent posts in the workforce. Without a stronger process, like zero-based budgeting,[6] the Board is likely to miss financial targets and underfund its strategic goals. The Health Board recognises this and expects major programmes in 2026, like ‘Foundations for the Future’ and the development of its long-term strategy and clinical services plan to lay the groundwork for a better approach.

65 For 2025-26, the Health Board set a savings target of £40 million. To achieve this, it used a mix of approaches:

- Setting an organisation-wide target to cut 1.5% from its budget; and
- Using the Value and Sustainability workstream to identify recurring savings

[6] Zero-based budgeting is a financial planning approach where every expense must be justified for each new period, starting from a ‘zero base’ to ensure allocations are based on current needs and priorities rather than historical spending.

66 When the Health Board submitted its 2025-26 financial plan to Welsh Government, it had only identified £20 million of the required savings. The full list of savings schemes was not completed until month six. The Health Board told us that the Value and Sustainability workstream is now working to identify a longer term “pipeline” of savings that can support the Health Board’s approach to cost improvements.

67 Since April 2021, the Health Board has received £42 million per year of additional Welsh Government strategic financial assistance. This funding supports planned care, unscheduled care and mental health service improvements. The Health Board has improved scrutiny of spending plans but the timing of this process, which took place after the financial year had begun, has also caused some problems. The scoring and scrutiny process for bids led to the funding becoming delayed, which meant that the Health Board struggled to use these resources for new transformation projects this year. Most of the money was already committed to cover ongoing staff pay, which meant there was little left to start new initiatives.

Financial management arrangements

68 The Audit Committee and the Board review the Health Board’s Standing Orders and Standing Financial Instructions regularly, most recently in October 2025. Officers report any breaches to the Audit Committee. The Committee also gets regular reports on the Health Board’s counter-fraud programme, high-value purchases, losses, special payments, and single tender actions. Whilst remaining high, the number of purchase orders that did not comply with Standing Financial Instructions in 2025-26 have reduced compared to previous years. The Health Board recognises that many of these are for known expenditure, but that the variable nature of the volume of purchase orders means that retrospective orders are produced.

69 The Health Board issued its accountability agreements for budget holders across the organisation in August 2025 (month five). In addition to being issued well into the financial year, the letters did not clearly state the delegated budgets. As a result of this and other issues, several accountability agreements were unsigned across the organisation at the time of our fieldwork. As of December 2025, 380 agreements across the organisation had been signed, and 50 were yet to be returned which crucially included 10 of the 14 budget holders within the Executive Team. We understand this has since improved with only 11 outstanding as of February 2026, with three of those within the Executive Team. Nevertheless, the Health Board needs to ensure that its arrangements for accountability agreements in future years enable budget holders to sign their agreements in a timelier way.

70 Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation (SORD), are up to date but budget delegation and authority is not operating as set out. In September 2025, the Board approved the latest version of the SORD. Our review found that the new SORD offers a more detailed framework to set out senior accountability more clearly for financial decision-making. However, we heard significant concerns during our interviews that additional central checks and controls are being put in place for expenditure which is within budget holders delegated authority, as set out in the SORD. We heard concerns that these further checks are contributing to delays in decision-making.

71 Whilst these additional centralised controls may be deemed necessary, they indicate that there is not full confidence in budget holders' ability to manage within their delegated budgets, and that there is still much work to do build a culture of financial maturity, responsibility and trust within the organisation. This may reflect historical weaknesses in financial management within the Health Board, with some budget holders overspending and concerns about the quality of business cases. During interviews we also heard that there is a history within the organisation of budget holders placing too much reliance on submitting business cases for additional funding, rather than prioritising spends within their existing budgets.

72 More helpfully, the Health Board is providing procurement training so staff know how to buy goods and services correctly. It also offers useful resources, including a Budget Manager's Handbook and a guide to buying goods and services. These materials should help staff follow good financial practice going forward.

73 The Health Board is improving how it prepares its annual accounts. The 2024–25 accounts received an unqualified True and Fair opinion. However, they also received a qualified regulatory opinion because the Health Board did not break even from 2022–23 to 2024–25. Our accounts audit found only minor errors, which were corrected during the review. We also noted major improvements in the Remuneration Report.

Monitoring financial performance

74 Financial reports to the Performance, Finance, and Information Governance Committee and the Board continue to be timely, comprehensive, and transparent. They provide good analysis on areas of spending, overspending, financial trends and risks. The reports set out the short-term financial challenges and identify where there are specific financial concerns.

75 The Health Board has made good progress in responding to our previous recommendations relating to financial management. This includes recommendations made in our Cost Savings Arrangements (2024) and Structured Assessment (2024, 2023 and 2022) reviews. It has strengthened the clarity of its savings and financial performance reporting. However, as noted earlier it still needs to develop a medium-term financial plan and improve its approach for issuing accountability agreements.

Recommendations

76 The following table details the recommendations arising from our work.

Recommendations

R1	The Health Board should ensure explanatory papers are always provided for items considered in private sessions of Board and committee meetings (see **paragraph 11**).
R2	The Health Board should upload AAA reports to the website within 14 days of the committee meeting to which they relate to support awareness of the key issues discussed and decisions taken in advance of confirmed minutes being published (see **paragraph 14**).
R3	The Health Board should increase the pace of its process to update high-risk policies (see **paragraph 16**).
R4	The Health Board should ensure that the Board receives JCC minutes and related assurance reports to enable it to discuss risks and implications of national commissioning arrangements (see **paragraph 19**).

R5 The Health Board should ensure that its executive leadership arrangements are supporting a collective and shared response to the organisation's key challenges. This must include:

5.1 Ensuring appropriate use of delegated responsibilities and accountabilities to enable the Chief Executive to have the capacity to operate at a slightly higher level (see **paragraph 30**).

5.2 Ensuring all Executive portfolios are deliverable and appropriate, support a fair distribution of responsibilities across the Executive Team and avoid the risk that leadership of the response to the organisations main challenges becomes vested in just a few individuals (see **paragraph 31**).

5.3 Identifying a deputy Chief Executive (see **paragraph 32**).

R6 The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports) (see **paragraph 20**).

R7 The Health Board should ensure that it has the appropriate programme management and governance arrangements in place to support the roll out of the Foundations for the Future Programme. Specifically, it needs to ensure that:

7.1 It has sufficient management capacity to support the timely roll out of the Programme (see **paragraph 52**);

7.2 All Executive Team members are appropriately sighted of, and aligned with the changes that the Programme intends to bring about (see **paragraph 33**);

7.3 Independent Members are appropriately briefed on the Programme and have sufficient opportunity to seek the assurances they need on its implementation (see **paragraph 52**).

R8 The Health Board should strengthen budget-setting approach to move away from the current position of rolling over existing budgets to one that is more zero based and reflects priorities and transformation needs in different parts of the organisation along with a more intelligence driven approach to savings planning (**see paragraph 64**).

R9 The Health Board should ensure accountability agreements are sent to budget holders earlier in the financial year as part of an approach which enables these agreements are signed in a more timely fashion (see **paragraph 69**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period September to November 2025:

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers.
- Model Standing Financial Instructions.

- Relevant Welsh Government health circulars and guidance.
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Standing Orders and Standing Financial Instructions.
- Key strategies and plans, including the IMTP.
- Key risk management documents, including the Board Assurance Framework.
- Annual Report, including the Annual Governance Statement.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chair of the Board;
- Vice-Chair and Chair of Performance, Finance and Information Governance Committee;
- Chair of Planning, Population Health and Partnership Committee;
- Chair of People and Culture Committee;
- Chair of Audit Committee;
- Chief Executive Officer;
- Executive Director of Finance;
- Executive Director of Nursing and Midwifery;
- Executive Director of Strategic Planning and Transformation;
- Executive Medical Director;
- Chief Operating Officer;
- Director of Corporate Governance; and

- Director of Environment and Estates.

We observed Board meetings as well as meetings of the following committees:

- Audit Committee;
- Quality, Safety and Experience Committee;
- Performance, Finance and Information Governance;
- People and Culture Committee; and
- Planning, Population Health and Partnerships Committee.

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Health Board in implementing outstanding recommendations from previous structured assessment reports.

Recommendation	Status
2024 Recommendation 1 The Health Board should progress its plans to introduce arrangements for an Executive Committee and its related operating arrangements by April 2025. **Target completion date**: April 2025	Complete (see **paragraph 33**).
2024 Recommendation 2 In the context of ongoing work in relation to the Foundations for the Future programme and strengthening its operational governance, the Health Board should develop a Terms of Reference for its Senior Leadership Team meetings to clarify the purpose of meetings and to ensure that the frequency of meetings is sufficient to effectively discharge its role. **Target completion date**: July 2025	In progress. The Health Board advises us that it is addressing this recommendations as it progresses the Foundations for the Future programme.

Recommendation	Status
2024 Recommendation 3 When the Board reports against decisions taken in private session or via Chair's Actions, it should ensure that, where relevant, the cost implications of decisions are clearly reported. **Target completion date**: January 2024	Complete (see **paragraph 12**).
2024 Recommendation 4 The Health Board should ensure review of minutes is a standing item on the agenda of each Remuneration Committee meeting (including additional meetings) to ensure the Board has access to an accurate and timely description of the decisions taken. **Target completion date**: January 2025	Complete. The Health Board has made improvements on this issue, although we note there were delays in confirmation of minutes for one meeting in 2025. We will continue to monitor as part of future structured assessment reviews.
2024 Recommendation 5 The Health Board should develop a structured programme of Board member visits, to include a mechanism to provide feedback to the Board. **Target completion date**: June 2025	In progress (see **paragraph 24**).

Recommendation	Status
2024 Recommendation 6 As part of the development of a meaningful Board Assurance Framework, the Health Board should provide Board members with further supporting detail on its strategic objectives to clarify what the objectives are seeking to achieve. **Target completion date**: January 2025	In progress (see **paragraph 34**).
2024 Recommendation 7 The Health Board should ensure that audit reports that are relevant to the remit of other Board committees are received and discussed by those committees, including periodic updates against any associated recommendations. **Target completion date**: April 2025	In progress. The Health Board has been presenting audit reports to other relevant committees during the year. However, committees do not receive updates against recommendations following receipt of the report.
2024 Recommendation 8 The Health Board should ensure that it appropriately engages with Board members and Regional Partnership Board partners in the process of developing future Integrated Medium Term Plans or Annual Plans. **Target completion date**: April 2025	In progress (see **paragraph 49**).

Recommendation	Status
2024 Recommendation 9 Where the Health Board needs to carry forward actions from one Annual Plan to the next, it should ensure that progress reports are clear on which actions have been retired or carried forward and provide clear and realistic milestones for those actions. **Target completion date**: April 2025	Complete (see **paragraph 58**).
2023 Recommendation 1 Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings. **Target completion date**: May 2024	Complete (see **paragraph 13**).

Recommendation	Status
2023 Recommendation 2 The minutes for some committee meetings are missing from the website many months after the meeting date. This affects timely public access to committee discussions. The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. **Target completion date**: July 2024	Complete (see **paragraph 14**).
2023 Recommendation 3 There has also been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported. **Target completion date**: June 2024	Superseded. The Health Board reviewed complaint data for this period. Although no clear cause for the data trend was found, the Health Board is confident that the new Quality Management System allows better monitoring and response to complaints.

Recommendation	Status
2023 Recommendation 5 Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, the Welsh Language Commissioner, the Health and Safety Executive, and the Public Services Ombudsman for Wales. **Target completion date**: August 2024	Complete. Recommendations from Healthcare Inspectorate Wales, Care Inspectorate Wales, the Health and Safety Executive and the Public Services Ombudsman for Wales are reported regularly to the Quality, Safety and Experience Committee via the Improving Quality Report.
2023 Recommendation 7 It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit. **Target completion date**: August 2024	No progress (see **paragraph 63**).

Recommendation	Status
2023 Recommendation 8 Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and the subsequent EY review has been slower than intended. **Target completion date**: September 2024	Complete.
2022 Recommendation 2 The Health Board is continuing to refine performance reporting into board and committees. However, there remain concerns around the quality of the performance report and the extent that stated actions will lead to the intended improvements. The Health Board should improve its performance assurance reporting, focussing more on the impact of performance improvement actions. **Target completion date**: 31 July 2023	Complete (see **paragraph 37**).

Recommendation	Status
2022 Recommendation 4 The Health Board has a significant number of policies overdue for renewal, which exposes the organisation to service and administrative risks. The Health Board should review and update Health Board policies, prioritising high importance policies first, including the policy on policies. **Target completion date**: September 2023	Complete. Whilst not all policies have been updated and there is further progress to be made **(see paragraph 16)** the policy for the management of Health Board-wide policies, procedures and other written control document was updated in 2024 and a plan is in place to review overdue policies, including prioritising high importance policies first.
2022 Recommendation 8 We found limited evidence of how the Health Board is implementing value-based healthcare operationally to its services to maximise value and efficiency. The Health Board should ensure reporting on its value-based healthcare programme focusses on the outcomes achieved. **Target completion date**: December 2023	Complete. The Health Board can demonstrate monitoring of outcome metrics in relation to its value-based healthcare programme.

Recommendation	Status
2022 Recommendation 12 There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation. **Target completion date**: December 2023	In progress. Whilst the Health Board can demonstrate some activity to identify funding gaps in its digital ambitions, we have not seen evidence of this in relation to estates, nor have we seen updates on either strategy to committees.

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Health Board in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

Recommendation	Status
2025 Recommendation 1 The Health Board should seek to obtain better ownership of financial targets and savings requirements by Directorates and the Integrated Health Communities through: • Demonstrating that base budgets have been informed by a clear understanding of the costs of services that are to be delivered. • Ensuring that savings targets are based on an analysis of the actual opportunities that exist within Directorates and IHCs as opposed to a pan-Health-Board savings target. • Ensuring that accountability letters are issued in a timely manner and clearly set out the roles, responsibilities, and accountabilities of the Directorates, Integrated Health Communities, and the corporate centre. **Target completion date**: October 2025	In progress (see **paragraph 65**)

Recommendation	Status
2025 Recommendation 2 The Health Board should strengthen its approach to the identification and delivery of savings by: • Identifying viable savings schemes to meet the Health Board's overall savings target earlier in the financial planning cycle. • Taking earlier remedial action to bring under-performing saving schemes back on track. • Maintaining a focus on the identification of saving schemes that deliver recurrent savings. • Securing greater engagement from clinicians in the development and delivery of savings schemes. • Introducing a more formalised escalation process where Directorates and IHCs are not delivering against their savings targets. **Target completion date**: July 2025	In progress (see **paragraph 65**)

Recommendation	Status
2025 Recommendation 3 When updating its savings guidance, the Health Board should ensure: • That the guidance provides greater clarity around how and when the views of service users and stakeholders should be canvassed in the process of generating savings ideas. • That the guidance reflects the new savings approach based around its Value and Sustainability Board framework • That the guidance clearly articulates the arrangements for assessing the impact of savings schemes on quality and patient safety, how they support the Health Board's strategic priorities, and impact on other services, as well as the integration with other initiatives (such as Value Based Health Care) **Target completion date**: March 2025	In progress. The Health Board has updated its savings guidance to reflect the new value and sustainability approach and to signpost managers to impact assessment guidance. Further updates are also planned as the Health Board changes its approach to allocating savings targets to departments.

2025 Recommendation 4 The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total. **Target completion date**: November 2024	Complete (see **paragraph 76**)
2025 Recommendation 5 5.1 The Health Board should ensure that it has a clear programme in place to address the financial capability gaps across the organisation to ensure operational managers have the necessary skills to support financial planning and savings delivery arrangements. 5.2 The Health Board should put arrangements in place to support Independent Members to gain a better understanding of the organisation's finances. **Target completion date**: November 2024	Complete (see **paragraph 75**)

2025 Recommendation 6 The Health Board should adopt a more systematic approach to the identification and sharing of learning on the delivery of savings schemes. This should include lessons learnt from Health Board savings schemes which have failed or underperformed and the sharing of good practice from the approach to savings schemes in other organisations. **Target completion date**: November 2024	Complete. The Health Board informs us that it proactively works with other organisations in NHS Wales to identify and share potential savings schemes.

3 Management response

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer
R1	The Health Board should ensure explanatory papers are always provided for items considered in private sessions of Board and committee meetings.	The Health Board new report template includes the 'rationale' for the Board and Committee considering items in Private; this is alongside the Protocol approved by the Board. The Health Board will ensure the consistency application of the protocol and will be reviewed by the Chair and Committee Chairs regularly.	End June 2026	Director of Corporate Governance
R2	The Health Board should upload AAA reports to the website within 14 days of the committee meeting to which they relate to support awareness of the key issues discussed and decisions taken in advance of confirmed minutes being published.	The AAA Reports are included within the Board Papers. The Corporate Governance Directorate will 'create' a new section on the committee papers webpage to ensure these are available and easily accessible.	September 2026	Director of Corporate Governance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer
R3	The Health Board should increase the pace of its process to update high-risk policies.	The Health Board has made progress on reducing the number of overdue policies. The Health Board will aim to eliminate the number of high- risk policies by end 2027 (with the exception of All Wales Policies) aligned to the improvement in policies processes.	March 2027	Director of Corporate Governance
R4	The Health Board should ensure that the Board receives JCC minutes and related assurance reports to enable it to discuss risks and implications of national commissioning arrangements.	The Health Board will ensure that the reports and minutes are available in the Corporate Governance Report	June 2026	Director of Corporate Governance
R5	The Health Board should ensure that its executive leadership arrangements are supporting a collective and shared response to the organisation's key challenges. This must include:	See below.		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer
	5.1 Ensuring appropriate use of delegated responsibilities and accountabilities to enable the Chief Executive to have the capacity to operate at a slightly higher level.	Implement the Director of Accountability Statement for 2026/27 which will ensure that Directors operate within their delegations.	March 2027	Director of Corporate Governance
	5.2 Ensuring all Executive portfolios are deliverable and appropriate, support a fair distribution of responsibilities across the Executive Team and avoid the risk that leadership of the response to the organisations main challenges becomes vested in just a few individuals.	Review of Executive portfolios has been completed as part of Foundations for the Future Programme, where necessary functions have been re-aligned and will be taken forward as part of the 'deliver' phase of the Foundations for Future Programme.	June 2026	Chief Executive Officer
	5.3 Identifying a Deputy Chief Executive.	The Chief Executive will consider the designation of the Deputy Chief Executive now that the Executive Team is in place.	September 2026	Chief Executive Officer
R6	The Health Board should ensure appropriate Executive Team member attendance during key items on committee agendas to facilitate effective discussion (i.e. audit committee for audit reports).	Lead Executives will be identified for attendance at meetings where there is a specific report being presented that requires their input.	June 2026	Director of Corporate Governance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer
R7	The Health Board should ensure that it has the appropriate programme management and governance arrangements in place to support the roll out of the Foundations for the Future Programme. Specifically, it needs to ensure that: 7.1 It has sufficient management capacity to support the timely roll out of the Programme. 7.2 All Executive Team members are appropriately sighted of, and aligned with, the changes that the Programme intends to bring about. 7.3 Independent Members are appropriately briefed on the Programme and have sufficient opportunity to seek the assurances they need on its implementation.	The Health Board has received reports on progress against the Foundations for the Future Programme; the frequency and regularity of reporting will increase as the programme moves through to the 'deliver' phase to consultation: From March 2026 onwards management capacity will be kept aligned to programme needs through ongoing review of workstream resourcing and strengthened Programme Team support where required. Executive alignment will be supported through an Executive review of the Programme Highlight Report and continued participation in Workstream Deep Dives. The People and Culture Committee will receive regular reports against the delivery of the programme with additional sessions arranged for the full board as necessary. Staff engagement will continue through the Programme's Communications Plan and dedicated intranet pages that provide accessible, up-to -date information.	March 2027	Programme Director

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

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer
R9	The Health Board should ensure accountability agreements are sent to budget holders earlier in the financial year as part of an approach which enables these agreements are signed in a more timely fashion.	Accountability Agreements will be issued at the beginning of the financial year.	April 2026	Director of Finance

4 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework sets out the risks linked to the organisation's strategic objectives, and the controls and assurances in place to manage those risks.
Clinical Strategy	A Clinical Strategy is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.
Integrated Medium Term Plan	An Integrated Medium Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Losses	Losses include things like theft, fraud, overpayments, or damage to property.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.

Term	Description
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation sets out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
SMART	SMART is a well-known framework for setting clear and effective objectives. It stands for Specific, Measurable, Achievable, Relevant and Time-bound.
Special Payments	Special payments are one-off payments made in unusual situations – like compensation or goodwill gestures – that fall outside of the organisation's normal business activity.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Betsi Cadwaladr University Health Board – Annual Audit Summary 2025

Date issued: March 2026

This document is a draft version pending further discussions with the audited body. Information may not yet have been fully verified and should not be widely distributed.

Contents

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Foreword

Adrian Crompton

Auditor General for Wales

I am pleased to share my Annual Audit Summary for Betsi Cadwaladr University Health Board. It summarises the main findings from my 2025 audit work undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004 and the Well-Being of Future Generations (Wales) Act 2015.

I provided opinions on whether the accounts were properly prepared and gave a true and fair view, in all material aspects, and whether expenditure and income have been used for the purposes intended and in accordance with the authorities which govern you.

My audit team has also assessed whether the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and acted in line with the sustainable development principle. In doing so, my audit team has undertaken my annual structured assessment work and reviewed planned care services and urgent and emergency care services. As set out in my audit plan, these reviews have been carried out in line with the International Organisation of Supreme Audit Institutions (INTOSAI) standards.

At the time of publishing this summary, the Health Board was escalated to Level 5 under the Welsh Government's escalation and intervention arrangements.

The detailed audit findings for each of my reviews are set out in the respective reports which my audit team have presented to the Audit Committee throughout the year. The performance audit reports are available on the Audit Wales website and further links are available in the summary.

The Annual Audit Summary should be shared with the Board. I will then make the summary available to the public on the Audit Wales website.

I would like to extend my gratitude to the Health Board's staff for their help and cooperation throughout my audit.

Your audit at a glance

I received the draft accounts in line with the statutory deadline of 2 May. The quality of the draft accounts and working papers were satisfactory.

In advance of the statutory deadline of 30 June 2025, I issued an unqualified true and fair opinion, and a qualified regularity opinion. I also issued a substantive report on the accounts. There were uncorrected misstatements in the accounts. There were also other significant issues to report including the need to address weaknesses in governance arrangements for senior officer appointments and inconsistencies in the recording and publication of declarations of interest.

My performance audit work found that Board and its Committees are operating effectively, and improvements are being made to corporate governance arrangements. However, executive leadership arrangements are still not working optimally and. I remain concerned about the continued absence of a clinical services plan.

Delivering the Foundations for the Future programme is going to be crucial in securing the improvements which are needed in the operating model and associated accountabilities. However, implementation timescales are challenging and will require executive ownership and wider staff buy in.

Despite strengthened financial oversight, the Health Board was forecasting a £17.4 million year-end deficit. My work has also identified the need for securing more timely issue of accountability agreements to budget holders and sign up to those agreements.

Significant service delivery challenges remain especially in planned and unscheduled care services, which will require continued and urgent focus to address.

My audit team made several recommendations to the Health Board which focus on strengthening leadership and some aspects of operational governance. Themes of wider recommendations included strengthening planning and associated service changes and better monitoring of additional Welsh Government funding.

There is still some work outstanding from my Audit Plan dated April 2025. My team expects to complete this work by the end of summer 2026.

Audit of accounts findings

Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides opinions on whether the accounts are properly prepared and give and true and fair view, in all material aspects, and the proper use ('regularity') of public monies.

My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

The draft accounts were presented for audit on 2 May 2025. This was in line with the deadline of 2 May 2025 set by the Welsh Government. The quality of the draft accounts presented for audit was generally satisfactory.

My audit opinions

I must report issues arising from my work to those charged with governance for consideration before I issue my audit opinion on the accounts. I reported these issues within my Audit of Accounts Report to the Audit Committee on 24 June 2025.

True and fair

A number of changes were made to the draft accounts arising from my audit work.

There were uncorrected misstatements following the audit which were due to insufficient evidence supporting capital additions recorded in March 2025. As a result, 'Assets Under Construction' (AUC) were overstated by £3.54 million, 'Other Prepayments' were understated by £2.41 million, and 'Capital Payables' were overstated by £1.14 million. At the conclusion of our work, uncertainty remained over additions recognised in the accounts, with a balance of £17.01 million remaining untested. When combined with the total identified errors, the maximum potential misstatement was £20.55 million. This value was below the audit materiality threshold, and therefore I was able to conclude that the accounts where not materially misstated for

this issue. The Capital Resource Allocation underspend in Note 2.2 was also understated by a corresponding amount.

I reported the following significant issues:

- Governance arrangements of senior officer appointments - audit work across 2022–23 to 2024–25 identified weaknesses in governance over senior officer appointments, including a contract discrepancy in 2024–25 for the Director of Corporate Governance, where contractual salary terms did not align with Remuneration Committee approvals. This highlighted the need for stronger controls and oversight in the preparation and review of senior staff contracts.
- Recording of declarations of interests - the 2024–25 declarations of interest process was undermined by inconsistent submission methods, missing signatures and dates, completion of forms by Corporate Governance staff on behalf of Board Members, discrepancies between submitted and published declarations, and multiple or conflicting declarations of interest, all of which required additional verification and correction.

I reported other matters as follows:

- Verifying and evidencing the receipt of capital equipment - the Health Board struggled to evidence the receipt of capital equipment, often needing to contact suppliers during the audit, and was unable to substantiate £3.54 million of additions in March 2025, with a further £17.01 million remaining untested. This highlighted the need to for the Health Board to strengthen documentation and evidence retention processes for equipment purchases.
- Timing of Capital Projects and Expenditure - around £31 million (60%) of capital expenditure was recognised in March 2025, requiring substantial additional audit testing to verify year-end cut-off. This placed significant pressure on both audit and finance teams, particularly given the wider lack of supporting documentation for goods receipted, resulting in delays and increased audit work.
- Pharmacy journals - review of 2024–25 pharmacy expenditure found numerous complex journal entries used to allocate costs and adjust prior accruals. As the Health Board does not operate a formal journal

approval process, there was an increased risk that errors or misstatements may occur and remain undetected.

- Compliance with Interim Appointment Guidance - Welsh NHS guidance issued in August 2024 required Welsh Government approval for all interim senior officer appointments. The Health Board did not obtain approval for a one-month extension of the Interim Chief Operating Officer's appointment, highlighting the need to strengthen internal controls to ensure full compliance with evolving governance requirements.
- Care home accommodation pooled budgets - the Health Board breached Regulation 19(1)(a) of the Partnership Arrangements (Wales) Regulations 2015 and its own partnership agreement by failing to make any payments to the North Wales Older People's Accommodation Pooled Budget during the year, meaning the pooled fund was not operational as required.

I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them.

Regularity

The Health Board is only allowed to receive income and incur expenditure in ways that follow the rules set by the authorities that govern it.

Further, where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

The Health Board did not achieve financial balance for the three-year period ending 31 March 2025, which I deem to be outside its powers to spend, so I issued a qualified opinion on the regularity of the financial transactions within the Health Board's 2024-25 accounts. The Health Board did not manage its revenue expenditure within its resource allocation over the three-year period 2022-2023 to 2024-2025, exceeding its cumulative revenue resource limit of £6,483 million by £31.5 million.

Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the failure to achieve financial balance and the failure to have an approved three-year plan in place.

Whole of Government Accounts

I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2025 and the return was prepared in accordance with the Treasury's instructions.

Performance audit findings

Structured assessment

My team looked at how well the Health Board is governed and whether it makes the best use of its resources. I found that the Board and its committees are operating effectively with open discussion and effective challenge. However, executive leadership arrangements are causing some concern. Despite there being a largely substantive Executive Team in place, the Chief Executive is still being drawn too extensively into operational issues and specific programme leadership. There is also a need to ensure executive portfolios support more collective organisational leadership by the Executive Team rather than this being vested in just a few individuals.

The Health Board's current operating model is recognised as not being fit for purpose. Much stronger and clearer accountabilities for performance is needed given the significant service delivery challenges being faced by the organisation. The Foundations for the Future programme that aims to introduce a new operating model is a necessary and appropriately ambitious initiative. However, its implementation is taking longer than originally planned. The revised implementation date of April 2026 looks very challenging given that limited and high-level information on the model has shared with the Board. The model will also require an extensive internal consultation exercise before it can be rolled out.

The Health Board is focusing strongly on the achievement of its statutory financial requirements. It is encouraging that it was able to submit a financially balanced medium-term plan, although the plan was not approvable due to a lack of detail on delivery approaches. A focus on longer term financial sustainability is still needed, although this is being impeded by the continued absence of a clinical services plan.

There is good oversight of financial performance but the Health Board is forecasting a year-end deficit position of £17.4 million as of month ten. It is also of significant concern that a number of accountability agreements for 2025-26 were signed very late into the 2025-26 financial year, including by several of budget holders in the Executive Team

.

I made nine recommendations to the Health Board within the following areas:

- Increasing transparency within board business;
- Strengthening lines of assurance to board committees;
- Strengthening resilience within the Executive Team;
- Ensuring financial controls are well-understood, clearly articulated and agreed; and
- Ensuring sufficient programme management capacity for its review of operating structures.

Managing planned care

My team looked at the progress the Health Board is making in tackling its planned care challenges and reducing its waiting list backlog.

I found that despite some improvements there are still significant numbers of long patient waits indicating that further sustained action by the Health Board is going to be needed to secure the required improvements. My reporting also highlighted the need to improve service efficiency, develop sustainable planned care improvements to meet growing demand, and strengthen reporting of harm that occurs as a result of delays in elective treatment.

I made six recommendations focused on:

- better understanding and forecasting capacity and demand;
- planning services to meet current and future demand;
- strengthening programme governance;
- strengthening clinical leadership in the planned care programme;
- ensuring planned care risks are effectively managed; and
- monitoring of the impact that additional planned care recovery funding is having.

Managing urgent and emergency demand

My team looked at how well the Health Board is managing demand for urgent and emergency care to reduce unnecessary pressure on the system.

I 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.

I made 15 recommendations focused on:

- planning;
- maximising information on and the use of urgent and emergency services outside of the Emergency Department; and
- monitoring of additional funding.

Performance audit work still underway

At the time of reporting, the following reviews from the 2025 Audit Plan were still underway at the Health Board:

- follow-up review of quality governance;
- review of use of Welsh Government strategic financial allocation 2020-2026
- review of digital transformation;
- review of estates management; and
- review of cancer services.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use three lines of assurance to show how we achieve this. We have set up an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality
Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Betsi Cadwaladr University Health Board – Audit Plan 2026

Date issued: April 2026

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.

Contents

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my 2026 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 25) sets out how we will ensure those standards of quality are met. Our latest annual audit quality report provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2025-26 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting standards and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I am also required to certify a return to the Welsh Government which provides information about the Betsi Cadwaladr University Health Board (the Health Board) to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- determine the level of misstatement that could cause the user of the accounts to be misled;
- assist in the scoping of our audit approach and resultant audit tests;
- determine sample sizes;
- assess the effect of known and likely misstatements in the financial statements; and

- report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

Represents 1% of gross expenditure based upon 2024-25 audited financial statements.

£25.04 million

Reporting threshold (trivial)

represents 5% of materiality.

£1.25 million

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report

£5,000

Related party disclosures (individuals)

£1,000

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Risk of fraud in expenditure recognition

There is a risk of material misstatement due to fraud in expenditure recognition and as such is treated as a significant risk.

The Health Board continues to experience significant financial pressure. At the end of February 2026, it reported a year-to-date deficit of £17.35 million and a forecast year-end deficit of £17.43 million, having moved from a planned break-even position earlier in the year. This position is not aligned with the Welsh Government requirement for the Health Board to deliver a break-even outturn at year end.

The Health Board is reporting £59.8 million of unplanned cost pressures, with the forecast year-end position supported by significant in-year mitigations, including accountancy gains of £16.8 million, unplanned

spend reductions of £27.5 million, and centrally imposed expenditure controls.

The Health Board is also required to utilise the capital funding allocated by Welsh Government. At the end of February 2026, it had incurred capital expenditure of £36.3 million against an allocation of £59.1 million for the year (including £2.2 million for IFRS16). This results in a substantial level of capital expenditure being required in March 2026, which heightens the risk that revenue expenditure may be inappropriately capitalised in order to support delivery of both the revenue outturn and the capital expenditure target.

These financial pressures increase the risk that management judgements and estimates may be biased towards achieving the forecast yearend deficit of £17.43 million, despite continued cost pressures, to be as close as possible to meeting the Health Board's financial duty. There is also pressure around potential withdrawal of non-recurrent funding due to financial performance.

There is also an increased risk that expenditure incurred around the year end may not be correctly treated, potentially resulting in the deferral or understatement of liabilities to achieve the most favourable possible year-end outturn.

Our planned response

My audit team will:

- perform year-end cut-off testing over both pay and non-pay expenditure, including review of transactions recorded immediately before and after year end and testing of post year end payments;
- undertake targeted testing of accruals and provisions, focusing on the basis for material accrual releases, the appropriateness of assumptions used, and consistency with post year end evidence;
- perform detailed testing of accountancy gains and unplanned spend reductions, agreeing movements to underlying balance sheet positions and assessing whether adjustments represent genuine in-year movements; and
- perform targeted year-end testing over capital expenditure, focusing on cut-off of late-year additions and creditors and the risk of revenue expenditure being misclassified as capital.

Failure of first financial duty

There is a significant risk that the Health Board will fail to meet its first financial duty to break even over a three-year period. As noted above, the position at the end of February shows a year-to-date deficit of £17.35 million and a forecast year-end deficit of £17.43 million. This, combined with the outturns for 2023-24 and 2024-25, predicts a three-year deficit of £49.33 million.

Where the Health Board fails this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty.

Our planned response

The audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Failure of second financial duty

The second financial duty requires the Health Board to prepare a rolling three-year Integrated Medium-Term Plan (IMTP) and to obtain approval of that plan from the Welsh Ministers.

Whilst the Health Board submitted a financially balanced plan to Welsh Government for 2025-28, Welsh Government did not approve the plan. This was due to what it deemed to be weaknesses in other areas, including details on how it would meet delivery requirements across several services.

Where the Health Board fails this financial duty, we will place a substantive report on the financial statements highlighting the failure.

Our planned response

The audit team will:

- review the Health Board's progress in preparing a rolling three-year Integrated Medium Term Plan (IMTP) for 2025-28, including evidence of Board approval and submission to Welsh Government;
- assess whether the Health Board's stated inability to produce a balanced budget for 2026-27 impacts the credibility and approvability of the IMTP;
- evaluate the completeness, accuracy, and consistency of disclosures in the financial statements and Annual Governance Statement relating to the second financial duty; and
- maintain ongoing audit dialogue with management to monitor developments in the planning process and consider the implications for audit conclusions and reporting.

Capital expenditure – timing and evidence

As noted previously, the Health Board is required to utilise the capital funding allocated by Welsh Government. At the end of February 2026, it had incurred capital expenditure of £36.3 million against an allocation of £59.1 million (including £2.2 million for IFRS16), resulting in a substantial level of capital expenditure being required in March 2026. This position mirrors that experienced in 2024-25, when £31.0 million of capital expenditure was incurred in the final month of the year.

During the 2024-25 audit, we identified capital additions recorded in March 2025 for which the Health Board was unable to provide sufficient supporting evidence to demonstrate that assets had been received or that related works had been completed by the year-end. Consequently, the Health Board was unable to provide sufficient appropriate audit evidence for £3.54 million of capital additions included in the accounts, with a further £17.01 million remaining untested. This value was below the materiality set for the audit and therefore we were able to conclude that the accounts were not misstated for this issue.

These issues were reported in our 2024-25 Audit of Accounts report, together with a recommendation that the Health Board strengthens its procedures for documenting equipment purchases. The recurrence of a similar capital expenditure profile in 2025-26 increases the risk that

inappropriate cut-off, early capitalisation, or misclassification of expenditure may again arise at year end.

Our planned response

My audit team will:

- undertake year-end cut-off testing over capital expenditure, focusing on capital additions recorded in March 2026 and testing post-year-end payments to assess whether expenditure has been recognised in the correct accounting period;
- review material capital additions recorded late in the year, obtaining supporting evidence to confirm that assets were received and, where applicable, that the related works were completed and the assets were available for use by 31 March 2026; and
- review capital accruals and capital creditors at year end, including comparison to post-year-end payments, to assess whether liabilities have been appropriately recognised and not deferred to support delivery of the capital expenditure target.

Governance arrangements of senior officer appointments

Our audit work conducted for the financial years 2022–23, 2023–24 and 2024-25 identified deficiencies in the Health Board's governance arrangements relating to senior appointments.

While there were notable improvements in governance arrangements during 2024-25, an issue was identified relating to the accuracy of contractual documentation for a senior officer role. Although remuneration was paid in line with amounts approved by the Remuneration Committee, the contractual terms did not fully align with the approved remuneration arrangements.

There is a risk that weaknesses in controls over senior staff contracts result in misalignment between contractual terms and Remuneration Committee approvals, increasing the risk of governance non-compliance and potential misstatement or irregularity.

Our planned response

My audit team will:

- review all contracts of employment for senior officers to confirm that contractual terms are consistent with remuneration approved by the Remuneration Committee; and
- agree remuneration paid to approved minutes and papers of the Remuneration Committee to confirm that payments are in line with governance approvals.

Remuneration report disclosures

There have been several new appointments to senior officer and board member posts during 2025-26 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature. We have also previously identified material issues with these disclosures.

Therefore, there is a risk that even low value errors in the disclosure could result in a material misstatement.

Our planned response

My audit team will:

- understand the movements in senior officers and the Board during 2025-26;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2026.

Our planned response

My audit team will:

- review the indices used by management for reasonableness:
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Health Board and the other body/party.

The Health Board has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature.

We identified inconsistencies in the way Board Members submitted their declarations during the 2024-25 audit which adversely affected the reliability of the information and the efficiency of the audit.

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances, including the process put into place for declarations of interest;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increase the risk of material misstatement.

Our planned response

My audit team will:

- review management's estimation process for the valuation of provisions;
- consider the competence, capability and objectivity of the management experts who are prepare the estimates; and

- ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **January to February 2026**	High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee
Interim **March 2026 to April 2026**	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy and early sample testing Draft audit plan
Fieldwork **May to June 2026**	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing and evaluate audit findings Audit closure meeting
Reporting **June 2026**	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:


Strategic planning


Financial planning


Performance and risk management


Workforce planning


Asset management


Collaborative working

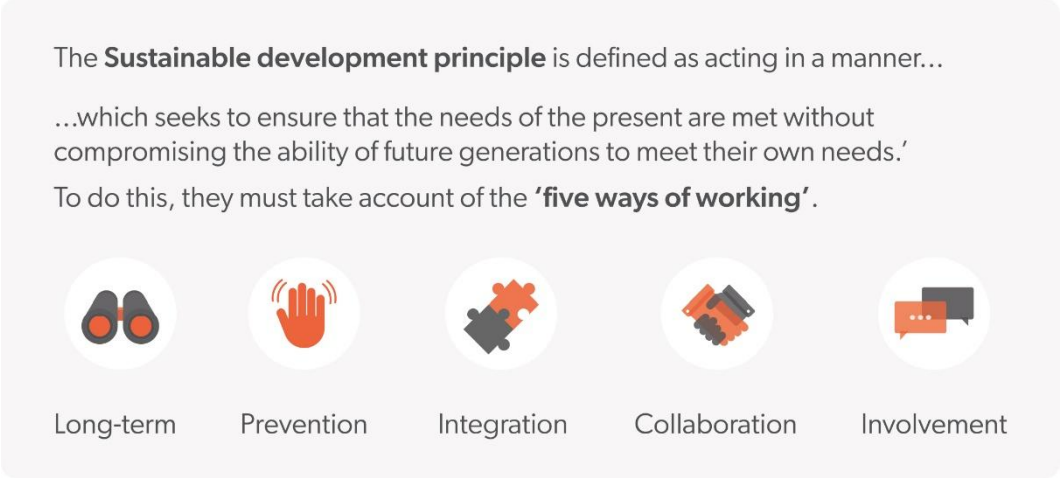

Overall governance.

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my planned performance audit work.

Structured Assessment

Scope of the work

Structured assessment will continue to form a key part of the audit work my audit teams do at each NHS body.

My 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources.

This work will also review how the audited body tracks progress against previous audit recommendations. This helps the audit team check that improvements identified in earlier audits are being addressed. It also helps us measure the impact of our work more clearly.

My 2026 Structured Assessment work will also inform our thinking on whether we should undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

All-Wales thematic review of the management and prevention of diabetes

Scope of the work

I plan to undertake work to examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. Whilst the exact focus of this work is still to be determined, it will focus on the ambitions set out in the Tackling Diabetes Together Programme and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.

Indicative timescales

Fieldwork to commence between September and October 2026 and reporting by the end of March 2027.

Local project work – Foundations for the Future

Scope of the work

My work will focus on the Health Board's implementation of its organisational redesign and Foundations for the Future operating model. My team will discuss the audit delivery approach with the Health Board. However, it is my current intention to review arrangements alongside and as the programme progresses, rather than a single one-off audit. This approach would lend itself to short periodic highlight reports to management on the risks, challenges and opportunities faced by the Health Board.

Indicative timescales

Fieldwork to commence May to November 2026. Reporting of key messages to the Audit Committee through the Annual Audit Summary at the end of this period.

Local project work – Primary care follow up

Scope of the work

My work will primarily focus on the Health Board's progress implementing the recommendations and areas for improvement identified in my previous Review of Primary Care. As part of the scoping of the audit, my team will consider new or emerging risks both in relation to the:

- sustainability/fragility of primary care services; and
- accessibility of primary care services and any consequent impact on wider services provided by the Health Board.

Indicative timescales

My team will aim to commence this work in September 2026 with a view to reporting by February 2027.

Ongoing considerations

My team will keep continue to consider performance, risks and challenges that the Health Board faces. Should other issues emerge which require audit examination I reserve the right to amend my programme of local project work accordingly.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and progress will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Your estimated total audit fee: £549,353

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Executive Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2026 (and 2025 for comparison)

Estimated fee for 2026 (£)[1]		Actual fee for 2025 (£)	
Audit of financial statements[2]	Performance audit work[3]	Audit of financial statements	Performance audit work
£321,356	£227,997	£305,325	£216,622
Total fee: £549,353		**Total fee: £521,947**	

[1] The fees shown in this document are exclusive of VAT.

[2] Payable November 2025 to October 2026

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will resume where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Matthew Edwards matthew.edwards@audit.wales	
	Financial Audit	**Performance Audit**
Engagement Leads	Matthew Edwards matthew.edwards@audit.wales	Tom Haslam tom.haslam@audit.wales
Audit Managers	Michelle Phoenix michelle.phoenix@audit.wales	Andrew Doughton andrew.doughton@audit.wales
Audit Leads	Natalie Cole natalie.cole@audit.wales Simon Monkhouse simon.monkhouse@audit.wales	Fflur Jones fflur.jones@audit.wales

I can confirm that the core members of my audit team are independent of the Health Board. Some junior members of our financial audit team do have close relations who work in the Health Board and we have put the necessary procedures in place for these staff to safeguard our independence and objectivity. I am not aware of any potential conflicts of interest that I need to bring to your attention.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Annual Report.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality
Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

Further Information

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.

Data tools to help you better understand public spending trends

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Archwilio Cymru
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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Audit Committee

ADRODDIAD GWRTH-DWYLL CH4 2025-2026
COUNTER FRAUD Q4 2025-2026 REPORT

Dyddiad y Cyfarfod **Date of Meeting**	21 April 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Danielle Kerr-Timmins, Head of Counter Fraud
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Russell Caldicott, Executive Director of Finance

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

The Local Counter Fraud Service (LCFS) continues to deliver the annual workplan in line with NHS Counter Fraud Authority (NHSCFA) Standards. A new Band 6 Local Counter Fraud Specialist has been appointed to strengthen team capacity on a three-month secondment entering the new financial year. Proactive delivery has continued, although output was affected by long-term sickness absence.

There are no matters for escalation arising from this report.

The Audit Committee is asked to:

NOTE the contents of the report
APPROVE the Counter Fraud Workplan for 2026-27.

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

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	25/03/2026	Counter Fraud Workplan 2026-27 approved at Executive Committee
Russell Caldicott	02/04/2026	Paper presented to Executive Director of Finance for approval – paper approved for Audit Committee

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
Not applicable for this report	NHSCFA – NHS Counter Fraud Authority NFI – National Fraud Initiative LCFS – Local Counter Fraud Specialist

1. Y SEFYLLFA / SITUATION

1.1 This report provides a high-level overview of counter fraud activity undertaken by the Betsi Cadwaladr University Health Board (BCUHB) Counter Fraud Team during Quarter 4 of 2025/26.

1.2 The Annual Report requires the inclusion of the Counter Fraud Functional Standard Return which is to be submitted at the end of May 2026. The Counter Fraud Annual Report for 20265-26 will therefore be presented to the Audit Committee in June 2026.

2. Y CEFNDIR / BACKGROUND

2.1 Performance Dashboard (Public Summary)

Further detail is included within Appendix A (Dashboard).

	Q1 25/26	Q2 25/26	Q3 25-26	Q4 25-26
Open Cases (end of quarter)	27	19	33	32
Cases Closed in quarter	17	16	0	13

Open cases represent a mix of allegations across workforce, patient, and primary-care-related categories.

2.2 Progress Against Annual Work Plan

Despite staffing pressures, progress continued across all four NHSCFA workstreams:

☑ Strategic Governance

- Ongoing delivery of the workplan in line with NHSCFA Standards.
- Preparation of the 2026/27 Counter Fraud Workplan, which has received approval from the Executive Committee.

☑ Inform & Involve

- Two Counter Fraud Clinics were held this quarter with 642 members of staff and visitors engaged with at Ysbyty Gwynedd and Ysbyty Wrexham Maelor.
- Recommendations provided based on investigations.
- Engagement with People Services on a new Parallel Investigations Procedure.

☑ Prevent & Deter

- Eight fraud risk reviews completed.
- One proactive exercise underway and two completed (details appropriately reserved for private session).
- Continued engagement with national fraud intelligence processes.

☑ Hold to Account

- Operational casework continued, with an increase in open cases (see performance dashboard).

2.3 Strategic Fraud Risk Environment

During Q4, the Health Board continued to experience a broad range of fraud-related allegations, consistent with national NHS trends. These include:

- Working whilst off sick
- Timesheet and overtime concerns
- GP and primary-care related issues
- Patient fraud and misuse of NHS services

Recommendations have been provided on a case-by-case basis in order to assist with mitigation of identified risks and engagement from staff has been positive.

2.4 Awareness, Culture and Engagement

- Work is underway to expand awareness activity into the new financial year, including Counter Fraud Clinics and wider staff engagement, as well as the introduction of a Counter Fraud Ambassador programme.
- The team continues to promote the Speak Up/Report Fraud channels across the organisation.
- The Counter Fraud Team is working closely with People Services to develop a new Parallel Investigations Procedure, designed to strengthen how the Health Board manages cases where both employment concerns and potential fraud issues arise. This procedure will set out clear roles, responsibilities and sequencing for each part of an investigation, ensuring that employment processes and fraud enquiries can progress efficiently, proportionately and without compromising one another. The work has been prompted by learning from recent cases, where better alignment between Counter Fraud and People Services would have improved timeliness, reduced duplication and ensured a smoother experience for staff involved. Once finalised, the new procedure will support more consistent decision-making, better information-sharing, and improved assurance for the organisation.

2.5 Key Achievements in Q3 (Public)

- Recruitment of a new Band 6 LCFS (three-month secondment) to enhance capacity.
- Successful national contribution to the appointment of the new Head of NHS Counter Fraud Service Wales
- Awareness campaign targeting the most common fraud risk theme (working whilst sick).
- Completion of eight fraud risk review exercises.
- Preparation of the 2026–2027 Counter Fraud Workplan.

2.6 Forward Look

- Increased proactive work following stabilisation of team capacity.
- Finalisation of the Organisational Fraud Risk Assessment.
- Continued refinement of workforce-related fraud prevention messaging.

The Counter Fraud Workplan for 2026-2027 has been completed and has received Executive Committee approval. The workplan has been provided in Appendix B and committee members are asked to review and approve the workplan.

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

3.1 Organisational Counter Fraud Risk Assessment

The Organisational Fraud Risk Assessment continues to progress well, with strong engagement from Executive Directors and senior managers across the Health Board. To date, 126 potential fraud risks have been identified, and these are now going through the formal process of being scored, evaluated and matched with appropriate mitigation actions. Early analysis shows that a significant proportion of these risks are assessed as low-level, which is a positive indication that existing controls and processes are largely effective. Work will continue into Q1 2026/27 to finalise the scoring, confirm risk ownership, and ensure that proportionate mitigation is in place across all areas.

3.2 National Fraud Initiative

The Health Board continues to participate in the National Fraud Initiative (NFI), a UK-wide data-matching programme led by the Cabinet Office, designed to detect and prevent fraud, error and overpayments by securely comparing datasets across public bodies.

The current NFI data-matching exercise is now coming to an end. Due to staffing changes and capacity pressures within the Counter Fraud Team, work this quarter has focused on reviewing the highest-risk and most critical matches. Although this phase of the NFI is drawing to a close, the team will continue to work through all remaining key matches to ensure that appropriate action is taken.

So far, the Health Board's review of NFI matches have identified some issues relating to declarations of interest, primarily concerning incomplete or inconsistent recording. Importantly, no fraud has been identified from this review, and the findings are being used to support awareness and strengthen compliance processes.

The next NFI cycle will begin in June 2026, when the Health Board will provide the required datasets for the new matching exercise. The resulting matches are expected in December 2026, after which risk-based review and follow-up will begin. Throughout this cycle, the Counter Fraud Team has been working with Audit Wales at a national level to improve consistency, share learning, and avoid duplication across Welsh NHS organisations, ensuring that the NFI is delivered as efficiently as possible.

There are no matters for escalation from this paper.

4. ARGYMHELLION / RECOMMENDATIONS

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

- **NOTE the contents of the report**
- **APPROVE the Counter Fraud Workplan for 2026-27**

5. APPENDICIES

a. Appendix A - Counter Fraud Dashboard Q4 25-26
b. Appendix B - Counter Fraud Workplan 2026-27

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	     1. Building an effective organisation Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirement

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*Equality Assessment is not required to be carried out, as this report is administrative in nature and reports the quarterly progress relating to Fraud, Bribery and Corruption.*
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*Socio-economic Impact Assessment is not required to be carried out, as this report does not deal with Health Board's strategic decisions.*
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality**	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply Na	**Meysydd Ansawdd** **Domains of Quality** All Apply

Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	

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

Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Relates to Counter Fraud Team progress therefore no assessment required.
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Open Investigations – End of Q4 25-26

Cases Under Investigation

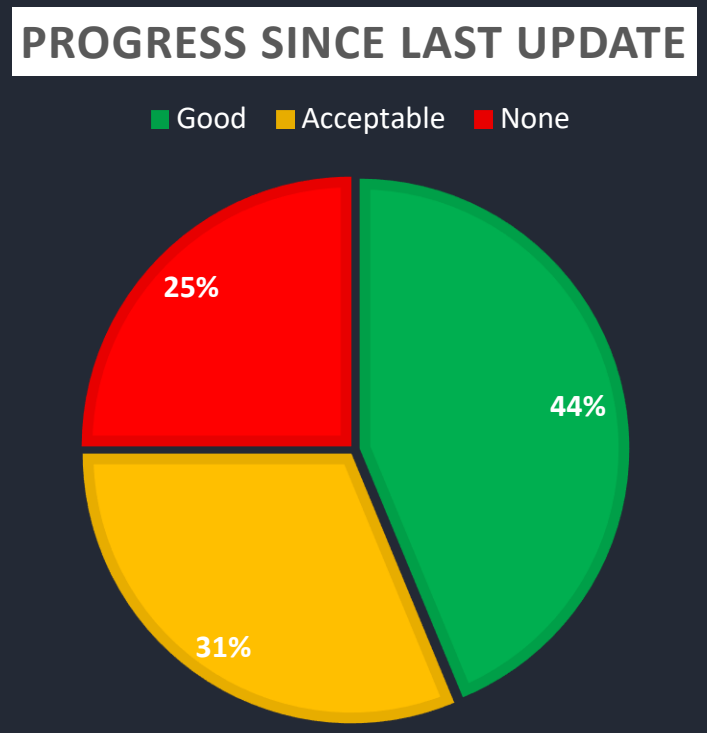
32

Referrals Received

12

Interviews Under Caution

5

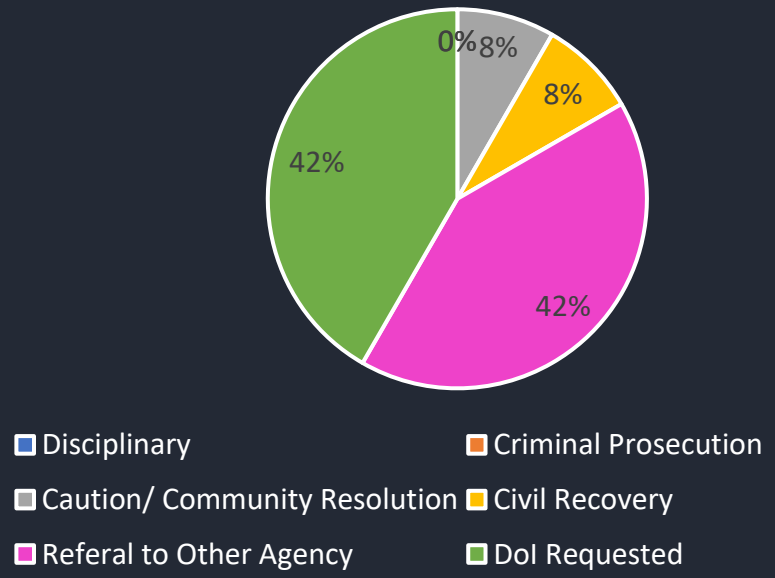


Fraud Type	Subtype	Count
NHS Staff Fraud – Employee Fraud	Employee Fraud – Other	**9**
	Working Whilst Sick	**8**
	Timesheet/Overtime Fraud	**3**
	Employee Declaration	**1**
	Staff Collusion – Bribery	**1**
NHS Patient Fraud	NHS Patients – Misuse of Prescriptions	**3**
	NHS Patients – Misuse of Services	**3**
NHS Supplier Fraud	Post-Contract Fraud – Invoicing Fraud	**1**
NHS Staff Fraud – General Practitioner	GP Practice Staff – Diversion of Funds	**1**
	GP Practice – Treatment Records/Claims	**1**
NHS Staff Fraud – Dental	Dental Contract – Dental Activity	**1**

Investigation Outcomes – Q4 25-26

Cases Closed	Referrals to Other Agency	Loss Identified	Loss Recovered	Loss Prevented
13	5	£10,118.35	£1818.67	£33,591.98

SANCTIONS/OUTCOMES



Fraud Identified in
46.15%
Of Cases

Sanctions/Outcomes
Applied
12

Average Days to Investigate
196

Proactive Work – Q4 25-26

E-Learning Training Compliance
91.39%

Risk Reviews
5

Presentations
0

Media Reports
2

System Weakness Reports Completed
0

Local Proactive Exercises Completed
2

Local Proactive Exercises in Progress
2

Engagement Events (People Seen)
642

21st April 2026 – Audit Committee

Counter Fraud Annual Workplan 2026 – 2027

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

This work plan sets out BCUHB's Counter Fraud Team proposed planned activity, objectives, and performance measures for the forthcoming financial year, developed in accordance with NHS Counter Fraud Authority (NHSCFA) requirements and the Government Functional Standard GovS 013: Counter Fraud. The proposed plan will consist of six Key Performance Indicators and four categories of workplan tasks.

The NHS Counter Fraud functional standard return may result in updates to national requirements. Although the submission date for 2026/27 has not yet been confirmed, it typically falls between late May and early June. To strengthen operational planning, ensure appropriate resource deployment, and support alignment with organisational priorities, the 2026–2027 work plan has been prepared in advance of the financial year.

Establishing a defined work plan provides clear organisational benefit by enabling a structured, risk-based approach to counter fraud activity; enhancing transparency of planned work; supporting prioritisation of resources; and ensuring that statutory, regulatory, and internal governance expectations are met. Should NHSCFA requirements change following submission of the annual return, the work plan will be reviewed and amended accordingly to maintain compliance and organisational assurance.

Proposed Key Performance Indicators

KPI	Target 2026–2027	Reporting
Fraud Awareness eLearning compliance	≥85%	Quarterly to Audit Committee and Welsh Government
Time to triage & action plan on CLUE case management system	≤30 days for 95% of new cases	Monthly internal; annually to Audit Committee
Case timeliness	≥80% of cases concluded or charged within 12 months (excl. repayment-only)	Quarterly internal; annually to Audit Committee
Proactive exercises completed	≥2 with documented outcomes	Quarterly to Audit Committee and Welsh Government
Intelligence dissemination timeliness	100% within 14 days	Monthly internal; annually to Audit Committee
Communications outputs	12 articles; 4 fraud clinics	Quarterly to Audit Committee

Proposed Workplan Task Objectives

Key Principle 1: Strategic Governance

Ensure arrangements embed Anti-Crime measures organisation-wide; maintain senior engagement and Audit Committee oversight.

Key Principle 2: Inform & Involve

Raise awareness; build a vigilant, fraud-intolerant workforce using multi-media channels.

Key Principle 3: Prevent & Deter

Identify anomalies; fraud-proof systems and minimise opportunities for fraud.

Key Principle 4: Hold to Account

Investigate suspicions promptly; apply sanctions and seek redress.

Key Principle 1: Strategic Governance

1.1 Workplan approval & review	**Agree workplan with Executive Director of Finance, Executive Committee and Audit Committee; review post Functional Standard return or any NHSCFA requirement changes.**	**Q1; review after 31 May 2026 and as required**
1.2 Accountable roles	**Maintain NHSCFA nominations for Accountable Board Member, Audit Committee Chair, Counter Fraud Champion and LCFS; notify changes.**	**Q1 and ongoing**
1.3 Audit Committee oversight	**Standing agenda item (public/private); include case updates and lessons learned in quarterly/annual reports.**	**Bi-monthly (in line with Committee)**

Key Principle 1: Strategic Governance

1.4 Stakeholder meetings	**Attend All-Wales Counter Fraud meetings to share intelligence and good practice and engage regularly with internal and external stakeholders.**	**Quarterly**
1.5 Government Standard 013 compliance	**Prepare and submit the Functional Standard return with signed assurance; include in Annual Report.**	**Q1**
1.6 Counter Fraud Tracker Tool	**Create a Counter Fraud Tracker tool to monitor recommendations made as part of Counter Fraud investigations and proactive exercises.**	**Q3**

Key Principle 2: Inform & Involve

2.1 Organisation Fraud Risk Assessment	**Complete and continuously review organisational risk assessment by engaging with risk owners identified in 2025–26.**	**Q3**
2.2 Communications strategy	**Continue with year 2 of comms plan including continuation of Counter Fraud Clinics and digital engagement.**	**Q1 setup; items monthly/quarterly**
2.3 Internal Audit liaison	**Share fraud risk concerns and use insights to shape proactive exercises and targeting.**	**Quarterly and ongoing**

Key Principle 2: Inform & Involve

2.4 Stakeholder Collaboration	**Explore the opportunity for a memorandum of understanding with North Wales Police to ensure more effective partnership working.**	**Q2**
2.5 Counter Fraud Ambassador Programme	**Set up a programme of staff members and train to be Counter Fraud Ambassadors; provide additional training, intelligence and case studies to share learning across the organisation.**	**Q4**
2.6 Awareness survey & feedback	**Run annual awareness survey; implement Microsoft Form for non-reporting feedback linked from BetsiNet.**	**Q4**

Key Principle 3: Prevent & Deter

3.1 Local proactive exercises	**Undertake one proactive exercise per quarter based on identified fraud risk areas. Record outcomes, prevention/recovery in CLUE and report outcomes to Audit Committee**	**Quarterly**
3.2 Fraud proofing of policies	**Engage with policy oversight to ensure new/reviewed documents consider fraud/bribery/corruption risk.**	**Quarterly**
3.3 National Fraud Initiative	**Engage with the National Fraud Initiative and ensure that high risk matches are appropriately investigated.**	**Ongoing**

Key Principle 4: Hold to Account

4.1 Being Accountable	**Launch a "Holding to Account" communications campaign featuring case mini-stories, manager responsibilities, reporting routes, and expectations for evidencing prevention controls.**	**Q3**
4.2 Investigation performance	**Triage new investigations and add action plans to CLUE within 30 days; maintain progress updates in line with NHSCFA/NHS CFS Wales.**	**Ongoing**
4.3 Sanctions & redress	**Apply appropriate sanctions; seek financial redress/recovery proportionately; target ≥80% of cases reaching decision/charge within 12 months (excluding repayment-only cases).**	**Ongoing**