Bundle BCU Audit Committee 14 October 2025

1 09:30 - SUPPORTING PAPERS

1.1 09:30 - AC25/141 Supporting Papers for Internal Audit Progress Report

AC25.142.1 Final Internal Audit Report - Civil Contingencies Act 2004v2 (BCU-2526-03)

AC25.142.2 Final Internal Audit Report - Public Health (BCU-2526-06)

AC25.142.3 Final Internal Audit Report Patient Experiencev2 (BCU-2526-10)

AC25.142.4 Final Internal Audit Report Consultant job plan followup (BCU-2526-27)

Corporate Legislative Compliance: Civil Contingencies Act 2004

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Review Reference	BCU-2526-03
Fieldwork	June - July 2025
Executive Sign Off	29th August 2025
Audit Committee	October 2025
Executive Lead	Jane Moore, Executive Director of Public Health
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Laura Howells, Audit Manager
	Ossama Lotfy, Principal Auditor

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Executive Summary

Purpose

To review the Health Board's compliance with the Civil Contingencies Act 2004 as a Category 1 Responder.

Overview

Overall, the Health Board has made progress in strengthening its Emergency Preparedness, Resilience and Response framework, and is supported by an enhanced governance structure and a well-defined work programme. Further work is continuing to progress several areas. Continued focus is needed to ensure comprehensive business continuity plan coverage, timely testing, staff training, and full alignment of risk management and policy processes to reinforce organisational resilience.

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

- Not all departments have submitted current business continuity plans (BCPs), and although 47 BCPs are active, a significant number (43) are still awaiting Director-level approval.
- Management is unable to provide completion rates for BCPs at either directorate or Health Board level, indicating a need for improved oversight and full coverage across all services.
- Testing of BCPs is inconsistent across departments; while some exercises have been carried out, many plans and incident responses remain untested.

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

- Actions are raised and noted within the Lessons and Debrief Log; however, this does not include dates for completion. Appropriate dates should be noted for each action to ensure there can be accountability that necessary actions are completed in a timely manner.

Scope & Assurance Summary

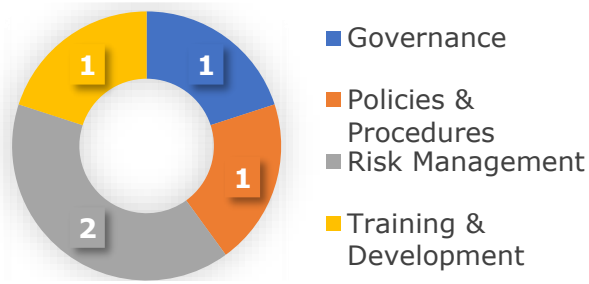
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There are effective governance arrangements in place to ensure the Health Board is meeting their obligations as a category 1 responder, with appropriate oversight and scrutiny of arrangements.	1	**Reasonable**
2	There are 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 who are responsible for these plans.	2,3,4 & 5	**Limited**
3	The Health Board is actively involved with stakeholders (local responders, national teams etc.), with sharing of information and lessons learnt from incidents / exercises captured and considered.	-	**Reasonable**

Management Actions

2 High Priority

3 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

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.	**Reasonable**

The Emergency Preparedness, Resilience and Response (EPRR) function demonstrates a clear structure and strategic alignment, with ongoing progress evident in business continuity and stakeholder collaboration. An EPRR Work Programme has been developed for 2025/26, which aligns with the Health Board's Annual Delivery Plan, Three-Year Strategic Plan, and the Wales Resilience Framework.

The programme is structured around ten Core Standards, adapted from NHS England best practice, in the absence of NHS Wales-specific EPRR standards. Each standard includes defined milestones and actions, underpinned by quarterly targets and supported by monthly assurance reporting.

The EPRR function reports through the Civil Contingencies Assurance Group (CCAG) to the Executive Committee and the Planning Population Health Partnership Committee (PPHP), ensuring appropriate oversight and governance.

The Business Continuity (BC) workstream is separately structured due to its scale and complexity. A central repository has been established to hold all BC and Major Incident plans. However, progress within this workstream is dependent on the timely submission of updates from service leads, with improvements continuing to be made.

Governance and regional engagement are well evidenced, with Health Board representation at the North Wales Local Resilience Forum (NWLRF). The Warning & Informing function is actively embedded in partnership with Corporate Communications, as demonstrated during recent regional incidents, such as the gas leak near Ysbyty Glan Clwyd.

The EPRR Annual Report 2024/25 has been approved at the Directorate level and was presented to the PPHP Committee on 3rd July 2025. We were informed this was presented and agreed at the July 2025 Board meeting.

Business Continuity (BC) planning is supported by service leads updating and submit their individual BC plans to the EPRR team. As this activity sits outside the direct control of the EPRR function, progress is reliant on engagement and capacity across the wider organisation.

	Key Findings	Risk & Impact	Agreed Management Action
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	Loss of service delivery during incidents through no continuity/ineffective plans in place.	**Agreed Actions:** 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

	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.		Assurance Group (CCAG) quarterly, or upon request identifying areas of non-compliance where action is required.
			Expected Evidence of Implementation: 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.
		Medium Priority	**Officer:** Deputy Head of EPRR **Target Implementation Date:** 31st December 2025
	Theme: Governance	Control Operation	

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.	**Limited**

A dedicated EPRR Resilience page is live on BetsiNet and is updated regularly. It serves as a central platform for all staff to access Business Continuity Plans (BCPs) and Major Incident Plans (MIPs). Management informed us that the uploaded plans are current; however, further work is required to ensure all services submit updated BCPs, and that these plans are appropriately tested. We reviewed the plans on BetsiNet and could not confirm all plans were up to date, as no review dates were noted within the plan.

Templates for BCPs and Business Impact Analyses (BIAs), which we are advised are aligned with ISO 22313 and Cabinet Office guidance, are available to staff. Several key policies and procedures are currently under review, including the Business Continuity Operational Response Framework and associated guidance documents.

As part of the 2025/26 EPRR Work Programme, there is a requirement to train staff on the Management on Call rota to ensure they possess the appropriate skills, resources, and support for command-and-control roles. A detailed competency matrix exists for these roles, categorised by command level (Bronze, Silver, Gold) and service type. Training records are maintained, and training needs are addressed in collaboration with Integrated Health Community (IHC) Directors. Although progress has been made, some rota staff remain untrained. As of 7 July 2025, 123 out of 173 Management on Call staff (71%) had completed the required training.

As of June 2025, 47 BCPs are active, with an additional 43 pending Director approval, bringing the total to 90. Each IHC has established local BC Groups responsible for developing and reviewing plans. Plans are recommended to be reviewed annually and exercised to ensure effectiveness.

We requested management to provide completion rates of BCPs at both directorate and Health Board levels. At this stage, they were unable to provide this information and are working with IHCs and pan- Health Board services to update and create the required plans. Once new structures are finalised, management expects to have improved oversight.

Internal exercises have been completed in three Mental Health units, with further exercises planned for Women's Services. However, testing remains inconsistent across services/departments.

The EPRR Risk Register is aligned with the Health Board's Risk Management Framework and includes one overarching risk for each of the nine national risk categories. These are uploaded to Datix, reviewed monthly, and reported quarterly to the Civil Contingencies Assurance Group (CCAG), which escalates concerns through the governance structure to Board level when necessary. Specific, Measurable, Achievable, Relevant, Time-bound (SMART) actions and mitigations are in place for all identified risks.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Incomplete Plan Coverage** Several departments have not submitted current BCPs and while 47 BCPs are live, a significant number (43) are still awaiting Director sign off. Management is unable to provide completion rates of BCPs at both directorate and Health Board levels - work remains to ensure full coverage across all services. There should be a	Loss of service delivery during incidents through no continuity/ineffective plans in place.	**Agreed Action:** 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).

	process to ensure all services within the Health Board have BCPs. The BCPs repository on BetsiNet appeared to hold outdated BCPs, such as the BCP for District Nursing created in 2022.		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. **Expected Evidence of Implementation:** Documentation outlining services and departments requiring business continuity plans, and completion rates. Evidence of reporting completion rates to the CCAG. Evidence of updated repository of completed and signed off business continuity plans on BetsiNet.
	Theme: Risk Management	**High Priority** Control Operation	**Officer:** Deputy Head of EPRR **Target Implementation Date:** 31st December 2025
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.	Business continuity plans do not reflect current practice and are ineffective when activated.	**Agreed Action:** 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. **Expected Evidence of Implementation:** A programme of regular testing exercises across the Health Board, covering all required departments.
	Theme: Risk Management	**High Priority** Control Operation	**Officer:** Head of EPRR **Target Implementation Date:** 31st December 2025
4	**Training** A training matrix is in place for Management on Call staff, but not all staff have completed the required training (current completion rate is 71%). We are unsighted on whether training plans are in place for Business Continuity Leads/Champions in areas not impacted	Lack of training could hinder effective continuity plan development and/or incident response.	**Agreed Action:** 1) To develop an EPRR training programme including front of house clinical/operational response needs and management on call training requirements 2) To create a dashboard by linking in the training compliance matrix already in place to include the total amount of Bronze / Silver / Gold on call colleagues who have completed the EPRR

	by Management on Call e.g., Corporate function continuity plans.		Major Incident training and the denominator. This will also identify those who are yet to attend. 3) To report all compliance from the dashboard summary to the Civil Contingencies Assurance Group (CCAG) quarterly, or upon request.
			Expected Evidence of Implementation: Improved training figures for targeted staff.
		Medium Priority	**Officer:** Deputy Heads of EPRR
	Theme: Training & Development	Control Operation	**Target Implementation Date:** March 31st 2026
5	**Outdated Policies and Procedures**. Core EPRR policies, templates, and guidance documents are still under review, such as the Business Continuity Operational Response Framework.	First line policies/procedures do not provide Health Board staff with current guidance and expected controls.	**Agreed Action:** All outstanding EPRR policies, templates, plans, policies and SOPs are agenda for approval/sign off at the next CCAG 30th September 2025.
			Expected Evidence of Implementation: Updated policies, procedures and guidance documents.
		Medium Priority	**Officer:** Deputy Head of EPRR
	Theme: Policies & Procedures	Control Operation	**Target Implementation Date:** 31st December 2025

Objective 3: The Health Board is actively involved with stakeholders (local responders, national teams etc.), with sharing of information and lessons learnt from incidents / exercises captured and considered.	**Reasonable**

The Health Board is engaged with local and regional partners to support multi-agency emergency preparedness, response, and recovery. The Emergency Preparedness, Resilience and Response (EPRR) team, including two Deputy Heads trained as National Structured Debriefers, lead structured debriefs following incidents and exercises. This process captures what went well, areas for improvement, and future recommendations, in line with national standards.

A central debrief log has been established and is maintained as part of the EPRR work programme. Actions are raised and noted within the Log; however, these do not include due dates to ensure accountability that necessary actions are completed in a timely manner.

Learning from both internal and regional incidents, such as the April 2025 Road traffic collision and gas leak near Ysbyty Glan Clwyd, is recorded and used to inform future actions. Lessons identified are tracked through a structured process involving presentation templates, Gantt charts for action tracking, and formal reporting. Accountability is assigned to responsible staff, and progress is followed up by the EPRR team.

The Health Board is represented at key strategic forums, including the North Wales Local Resilience Forum (NWRF) Executive Meetings and Coordination Group meetings. Meeting minutes confirm attendance and active participation. The Health Board is also involved in various Local

Resilience Forum sub-groups, including those for Health & Social Care, Environment, and Infrastructure, with representation from the EPRR Leads and Deputies. New groups such as the Lessons Management Group have also been established.

Information and learning are regularly shared with staff via the Health Board's internal platforms, including BetsiNet, Microsoft Teams, and email distribution lists. Information is also communicated via the Corporate Communications Team, to ensure wider awareness of incidents and updates.

Overall, there is evidence of stakeholder engagement and learning from incidents.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

Public Sector Internal Audit Standards

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

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Public Health – Grant funded activity

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

Contents

Review Reference	BCU-2425-06
Fieldwork	July - September 2025
Executive Sign Off	October 2025
Audit Committee	October 2025
Executive Lead	Jane Moore Executive Director of Public Health
Audit Team	Dave Harries, Head of Internal Audit
	Nicola Jones, Deputy Head of Internal Audit
	Laura Howells, Audit Manager

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Executive Summary

Purpose

To review the use of grant funding for the delivery of Prevention and Early Intervention Public Health programmes, and how this is monitored across the Health Board.

Overview

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

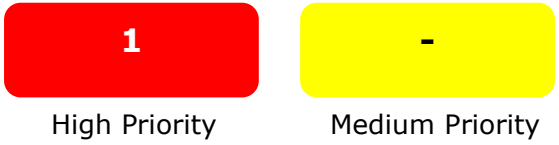
- Some posts are not permanent and are only offered on a fixed term basis due to their reliance on recurrent grant funding. If staff leave or posts are vacant, expected delivery of outcomes may stall.

Overall, the findings are positive. Oversight and monitoring arrangements for both the Healthy Weight: Healthy Wales Whole System Approach (HWHW WSA) grant and the Prevention and Early Years (PEY) grant reviewed as part of this audit are well established, with regular reporting through the Health Board's governance structure. Progress updates and financial monitoring discussions are documented, with issues such as sustainability of posts and reliance on non-recurrent funding escalated where appropriate.

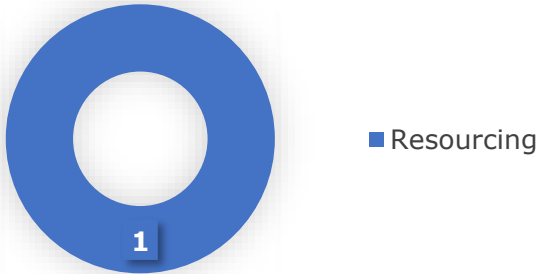
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Grant funds allocated to service areas across the Health Board via management through the Public Health Directorate are used appropriately and support the objectives and expected outcomes outlined for agreed funding	1	**Reasonable**
2	There is effective oversight and monitoring on the use of these funds / outcomes to ensure the accountable Director can provide assurance to report to Welsh Government / Public Health Wales that the agreed funding has been utilised appropriately.	-	**Substantial**

Management Actions



Themes



Risk Types

Quality or Safety Issues

Public Health grants – At a glance

This audit focused on two grants in detail:

Healthy Weight: Healthy Wales Whole Systems Approach (HWHW WSA) Grant

Healthy Weight: Healthy Wales (HWHW) is the Welsh Government's long-term, whole-system strategy to reduce obesity. Its Leadership and Enabling Change theme is delivered by all seven health boards.

In Betsi Cadwaladr University Health Board (BCUHB), a Principal Public Health Practitioner and Senior Public Health Practitioner are funded through the HWHW WSA grant to lead and coordinate healthy weight work across North Wales.

Prevention and Early Years (PEY) Grant

This grant is provided by Welsh Government to all Health Boards and funds delivery of two national priorities:

- Tobacco Control.
- Healthy Weight.

Each has its own strategy with two-year delivery plans. Health Boards are expected to implement their actions locally, using PEY funding to commission services tailored to population needs.

The funding provided for each grant is:

Grant	2024/25	2025/26
Healthy Weight	£145,549	£138,549
Prevention and Early Years	£1,237,757	£1,237,757

The following services have posts funded through the PEY grant. For those positions that are permanent, removal of the grant would become a cost pressure on the respective service (not on the Public Health Directorate). All fixed term contracts will end 31st March 2026. Positions below range from 0.1 whole time equivalent (WTE) to 1 WTE.

Service	Number of fixed term positions	Number of permanent positions
Dietetics	4	13
Help me Quit	6	7
Smoke free environment officers	2	1
Weight management services	8	0
Infant feeding	12	0

Findings & Agreed Action Plan

Objective 1: Grant funds allocated to service areas across the Health Board via management through the Public Health Directorate are used appropriately and support the objectives and expected outcomes outlined for agreed funding.	**Reasonable**

Overview / Summary of Observations

Our review focused on the two grants noted above.

Healthy Weight Healthy Wales Whole System Approach (HWHW WSA) Grant

The HWHW WSA grant of £145,549 was allocated to deliver the Healthy Weight: Healthy Wales strategy. Our review confirmed that expenditure was aligned with the grant's goals. The Strategic Delivery Plan 2024–26 demonstrates progress through three priority working groups: access to affordable food, schools, and workplaces. Outcomes included responding to food planning applications, establishing a regional food partnership, and piloting whole-school physical activity initiatives.

Expenditure was linked to objectives set out in the WSA Programme Document, such as developing leadership, building capacity, and embedding shared learning. Evidence from reports confirmed that grant funds supported staff time, policy development, and partnership engagement, which were essential for delivery.

Budget monitoring was robust. Budget trackers showed allocations across staffing and activities with budget vs actual spend recorded. Compliance with terms and conditions was demonstrated.

Prevention and Early Years (PEY) Grant

The PEY grant covers Healthy Weight and Tobacco Control programmes. We found spending to be appropriate. In Healthy Weight, funding supported dietetics, infant feeding, and adult weight management services. Underspends were reallocated effectively, for example to increase digital weight management access and resources for vulnerable groups. In Tobacco Control, the grant funded 4.5 whole time equivalent (WTE) advisors for the Help Me Quit in Hospital programme and supported initiatives such as smoke-free environments and anti-illegal tobacco campaigns.

Expenditure was consistent with objectives, with plans and reallocations submitted to Welsh Government. Monitoring was robust, with monthly budget reviews, regular oversight, and the use of a new performance portal. Assurance was reported by exception, and remedial actions agreed where required.

Some posts are not permanent and are only offered on a fixed term basis due to their reliance on recurrent grant funding. Conversely, the use of fixed term contracts risks long established staff leaving their post due to the uncertainty this type of contract creates. This risk forms part of the corporate risk noted within the Corporate Risk Register - CRR24-08. It has a score of 16 and 14 mitigating controls in place. Further details can be found on the Public Health grants page (page 2).

	Key Findings	Risk & Impact	Agreed Management Action
1	**Recurrent Funding** Not all posts are permanent and are offered on a fixed term basis. Delays in funding allocation from the Welsh Government	There is a risk of non-delivery of key national targets	**Agreed Action:** Public Health Directorate to request the development of plans from service areas at risk, which prepare for the following:

	has posed challenges to filling these positions. The Head of Public Health Assurance & Development informed us that there had been instances of established staff leaving their posts due to the uncertainty around their role caused by funding delays (we have not verified this). If staff leave or posts are vacant, delivery of outcomes would stall, as there are few other budget lines for external commissioning or system delivery.	without the required trained staff, and potential cost pressure on the Health Board.	• Continuation of non-recurrent grant funding at the same level • Reduction of non-recurrent grant funding • Discontinuation / withdrawal of non-recurrent grant funding Plans will reference: • How each scenario will impact on staffing levels and mitigation of the associated risks • Options for the continuation of delivery against key national targets This will include confirmation of the position in relation to the HWHW staff within the Public Health Directorate. Public Health to highlight risks to W&OD in relation to fixed term contracts funded via grants.
			Expected Evidence of Implementation: • Plans are received from each service area within input from Public Health Directorate. • Evidence of risk escalation to W&OD.
		High Priority	**Officer:** Executive Director of Public Health
	Theme: Resourcing	Control Design	**Target Implementation Date:** 31/1/2026

Objective 2: There is effective oversight and monitoring on the use of these funds / outcomes to ensure the accountable Director can provide assurance to report to Welsh Government / Public Health Wales that the agreed funding has been utilised appropriately.	**Substantial**

Overview / Summary of Observations

HWHW WSA grant

Oversight and monitoring of the HWHW WSA grant is through a number of groups/committees including the Performance and Risk Management Group (PRMG). The group's Terms of Reference confirm its responsibility for reviewing performance, risk, and resources, and agendas and notes show that healthy eating monitoring is a standard agenda item. The notes from meetings evidence grants are reviewed and scrutinised.

Monitoring does not take place at PRMG alone. The Population Health Executive Delivery Group (EDG) received updates last year when it was in place - this has since been paused and re-established as the Prevention, Population Health and Early Intervention EDG with the first meeting held in July 2025. The Planning, Population Health and Partnerships Committee also receives regular updates, including quarterly reports (this grant forms part of a larger report). In addition, the Strategic Partnership Group (SPG) meets quarterly to review monitoring information with input from partner organisations, escalating issues where required.

Grant fund use and risks are discussed and escalated where necessary. Notes from the various groups above show issues being escalated appropriately.

PEY Grant

Monitoring of the PEY grant also takes place at PRMG, with reports regularly reviewed. Progress is reported to the PPHP Committee, which highlighted outcomes such as exceeding Tier 1 smoking cessation targets. The Tobacco Control Management Group receives updates on PEY funding, including budget monitoring and programme delivery.

Escalation of issues has been noted through the Executive Committee decision-action log and the risk regarding reliance on non-recurrent funding is on the Corporate Risk Register (CRR24-08). The Help Me Quit in Hospital evaluation further highlighted risks associated with PEY-funded posts. PRMG and PPHP reports consistently show progress, providing assurance that effective oversight and monitoring arrangements are in place.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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Patient Experience

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Reasonable Assurance

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Executive Summary

Purpose

To review the processes in place for capturing and utilising feedback to improve patient experience across the Health Board.

Overview

The objectives in this review were limited to assessing adherence to the Wales People's Experience Framework and how this has been implemented by the Patient Experience Team.

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

- There is limited evidence that learning from feedback, whether this is from patients or reviews by other bodies / regulators, is used to inform and drive improvement across the Health Board.
- We note a briefing is sent to the First Minister however we have not evidenced this being presented within the Health Board for assurance, thus ensuring consistency in data received.

We note there has been considerable work undertaken to collate and analyse feedback from patients, and sharing of this through the Health Board, however it is recognised by management that further development is required to ensure that patient feedback is affecting change in the organisation.

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

- Training is currently on an ad hoc basis - without proper training, staff may lack the skills to effectively communicate and empathise with patients, leading to lower satisfaction levels.
- There is potential for management to conduct monthly reconciliations to ensure that all emails within the PALS system are being addressed.
- Attendance at MHLDs Local Strategic Patient Carer Experience Group meetings is poor and requires monitoring.
- Our review of the evidence indicates that correspondence is often exchanged across the Health Board outside regular administrative hours. It is unclear whether this practice is sustainable, and it may have long-term implications for the health and wellbeing of staff.

Scope & Assurance Summary

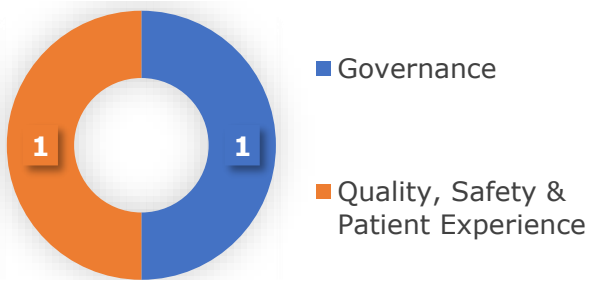
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate mechanisms and resources are in place for the collation and analysis of patient feedback, with the identification of trends and themes.	-	**Substantial**
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.	1 & 2	**Reasonable**
3	Patient experience is monitored and reported to the Health Board (or appropriate sub-committee).	-	**Substantial**

Management Actions

1 High Priority

1 Medium Priority

Themes



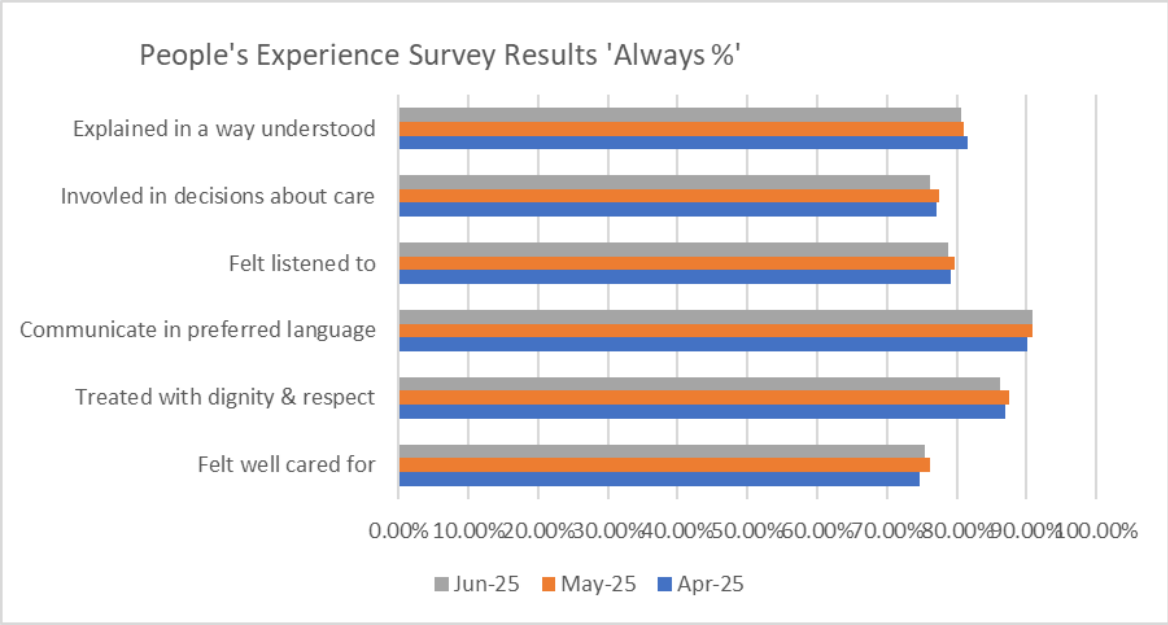
Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

A report submitted monthly to the First Minister, details in June 2025, a total of 6,279 responses for the Health Board were collected from the All-Wales People's Experience Survey (PES). The data below shows the survey results where patients answered 'Always', for April – June 2025.

Fig 1 – data from First Minister report June 2025



Findings & Agreed Action Plan

Objective 1: Appropriate mechanisms and resources are in place for the collation and analysis of patient feedback, with the identification of trends and themes.	**Substantial**

The CIVICA system is used across all Health Boards in Wales to gather feedback from patients, carers, and relatives using standard surveys. Feedback can be provided through multiple channels, including paper forms, online submissions, ward iPads, feedback kiosks, and SMS messages. On average the Health Board receives 5,000 feedback returns per month.

Other avenues for capturing patient experience include:

- Care 2 Share - interviews are undertaken by PALS (Patient Advice and Liaison Service) staff with patients who are on a ward.
- Patient Stories – patients share their personal experiences during their stay with the Health Board.
- LLAIS Feedback - an independent statutory body set up to capture views and experiences of patients.
- Chaplain & Spiritual Care Service – Chaplaincy inquiries are being recorded and reported.
- SWAN bereavement - two Macmillan SWAN Specialist Bereavement Nurses started in post. These posts sit within the Patient Experience Department with the overall aim of improving end of life experiences for patients, relatives and staff.

The Health Board is one of only three across Wales that offers a dedicated Patient Advice and Liaison Service (PALS) service, as this is not a mandatory requirement.

Enquiries are mainly received via staffed telephone lines and email. The phone system includes menu options, introduced in response to concerns related to waiting times. Enquiries made outside of office hours are redirected to an online service, which offers assistance; otherwise, they are addressed the next working day. Additional resource is allocated during incidents or events that are likely to increase the volume of enquiries to the Health Board.

Co-ordinators complete a first contact form which is then input onto the DATIX system and shared with the appropriate service in order to facilitate a response. For the month of June 2025 PALS enabled the resolution of a total of 608 enquiries, including 23 compliments and 4 suggestions for improvement.

A Quality Dashboard has been developed, which continuously updates at midnight, identifies themes and trends using data from the CIVICA and DAITX systems. The three main themes currently identified at the time of writing the report are: -

- Appointments.
- Clinical treatment or assessment.
- Communication.

A dashboard report had been developed which highlights key themes, subthemes, and associated narrative, enabling the team to pinpoint areas for improvement. Although the report is still pending approval, it was shared during the Strategic Patient Carer Experience Group meeting held on 17 July 2025, which we observed.

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.	**Reasonable**

Feedback from patients is shared with staff in a number of ways:

- Care 2 Share interviews - "You Said, We Did" learning is developed in partnership with Ward Managers. This includes patient feedback and the actions taken in response, both positive and negative. This information is also displayed on the wards for everyone to see.
- Responses from the CIVICA survey questions are publicly displayed on the wards for everyone to view.
- Feedback reports to service areas that provides a quarterly summary of patient and carer experience feedback.
- DATIX enquiries reports, including the department/speciality, summary of the issue and compliments are sent out to all IHCs and divisions on a weekly basis.

PALS officers deliver a range of training sessions to frontline staff, including Patient and Carer Experience (PCE) Training and annual PALS and Complaints Training for District Nurses at Wrexham University. These sessions cover how information is recorded and highlight recurring themes and trends. Although PCE training is not mandatory and is not part of the staff induction programme, it is important to consider offering some form of patient experience training to all staff, as every individual plays a role in shaping the overall patient experience.

There is also reporting on patient experience through the following:

- Patient Stories are captured with the consent of the patient and shared throughout the appropriate sub committees and Health Board meetings.
- A Citizens Experience report is presented to the Health Board, which offers insights into key themes from recent citizen engagements, encompassing data on enquiries, compliments, and patient feedback.
- A Protected Characteristics report is presented to the Patient and Carer Experience Group, which includes patients who may have long-standing conditions like deafness, severe hearing impairment, blindness, or partial sight. These patients might experience more negative outcomes due to their conditions.
- Monthly reports are submitted to the First Minister which details themes and trends in relation to patient experience.
- Social media promotions provide evidence of feedback from patients i.e. sharing stories, PALS promotion.

While we observed some service changes resulting from patient feedback—such as those highlighted in the Citizens' Experience Report, feedback on protected characteristics, and patient stories—overall, there remains limited evidence of widespread service improvements across the organisation."

A dashboard report has been developed and is currently under review. It identifies key themes and sub-themes, which will support team insights and guide organisational improvement efforts.

	Key Findings	Risk & Impact	Agreed Management Action
1	The organisation collects patient experience feedback through various channels, however there is limited evidence to demonstrate that feedback is currently being used to drive improvement through the Health Board per the Welsh Government People's Experience Framework self-assessment	Missed opportunities to improve patient care and experience.	**Agreed Action:** • Conduct a baseline audit of current feedback mechanisms and usage. • Engage with stakeholders to co-design a feedback-to-action pathway.

	tool (page 26 Using People's Feedback to Drive Quality Improvement and Learning). It is noted that the Patient Experience Team recognise this issue and are working towards initiatives to address this. This should include ensuring that the Patient Experience Team are sighted on relevant patient experience feedback / information included in external reports / reviews.	Reduced public confidence in the Health Board's commitment to listening and learning.	• Pilot the learning repository in selected services to test usability and impact. • Report progress to the Quality, Safety & Experience Committee on a quarterly basis **Expected Evidence of Implementation:** Feedback is linked to specific improvement actions with assigned responsibilities and timelines.
		High Priority	**Officer:** Head of Patient Experience **Target Implementation Date**: 31st March, 2026
	Theme: Quality, Safety & Patient Experience	Control Design	
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.	Data provided may not align with other reports presented to the Health Board, potentially leading to inconsistent reporting	**Agreed Action:** A protocol/operational procedure will be published whereby all First Minister/Minister briefings are routed via the Chief of Staff for issue. **Expected Evidence of Implementation:** 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.
		Medium Priority	**Officer:** Chief of Staff **Target Implementation Date:** 3 October 2025
	Theme: Governance	Control Operation	

Objective 3: Patient experience is monitored and reported to the Health Board (or appropriate sub-committee). **Substantial**

There is reporting to the Health Board on patient experience via a Citizen Experience report, which was presented at the Health Board meetings in January and May 2025. This report provides a summary of key themes from recent citizen engagements, including data on enquiries, compliments, and patient feedback. Additionally, an integrated quality report was presented on March 27, 2025.

We reviewed the papers of the Quality, Safety, and Experience Committee (QSE) meetings held in December 2024, February 2025, and May 2025. Each included an Integrated Quality report that provides updates on patient experience. Information reported includes:

- Key findings from the All-Wales Real-Time Patient and Carer Feedback Survey.
- Feedback on what patients said was good about their experience.

- Feedback from patient services in Emergency Departments.
- Common themes of feedback.
- Accessible Health Care for protected characteristics.

The Strategic Patient Carer Experience Group (PCEG) meets monthly. We reviewed the papers for the meetings March to June 2025 and observed the July 2025 meeting. Discussions at the meetings included areas such as protected characteristics, patient stories, quality dashboard, and insights and learning drawn from Patient and Carer Experience within Integrated Health Community (IHCs) and Specialist Services. Chair's reports from the Group are regularly provided to the Executive Quality Delivery Group (EQDG).

There are local Strategic Patient Carer Experience Group meetings in place which include local service updates, patient stories, patient feedback from CIVICA, PALS activity and items for escalation. Evidence of these meetings was provided through minutes from the IHCs in East, Central, and West regions, as well as from the Mental Health and Learning Disabilities service. We note attendance at MHLDs Local Strategic Patient Carer Experience Group meetings is poor and should be monitored to ensure effective meetings.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

Follow-up: Consultant Job Planning

Final Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board

Contents

Review Reference	BCU-2526-27
Fieldwork	August-September 2025
Executive Sign Off	October 2025
Audit Committee	October 2025
Executive Lead	Clara Day, Executive Medical Director Georgina Roberts, Interim Executive Director of People Services and Organisational Development (POD)
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit

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

Executive Summary

Purpose

The overall objective of this audit is to provide the Health Board with assurance regarding the implementation of the agreed management actions from the *Consultant Job Planning (BCU-2425-20)* review, rated unsatisfactory, that was reported as part of our 2024/25 work programme. The scope of this follow-up review does not aim to provide assurance against the full scope and objectives of the original review.

The report identified eleven issues for management consideration; all eight high-risk actions had agreed implementation dates no later than 31 May 2025; three medium risk issues (Issue 2, 4 and 9) have agreed implementation dates of 30 September 2025. As the high-risk issues are now past the agreed implementation date, we agreed with management to follow these up; the three medium-risk issues will be followed up as part of the routine follow up process undertaken in conjunction with the Corporate Governance Directorate.

Overview

The table below illustrates the status of the agreed actions; we found only one issue can be fully closed with another partially implemented.

	High	Medium	Low	**Total**
Closed	1	-	-	**1**
Partially Implemented	1	-	-	**1**
Outstanding	6	-	-	**6**
Total	**8**	**-**	**-**	**8**

Some progress has been made - the Health Board's strategic objectives have been refreshed and updated within the EJob plan system; and we were able to evidence inclusion of these within our sample of job plans reviewed. We found localised good practice in both Women's Services and IHC West where job plan matters formed part of meeting agendas.

However, the remaining high-risk issues have yet to be implemented despite these being agreed by management within realistic timelines.

- The Health Board's Job Planning Compliance is currently at 43% (1st September 2025); it is highly unlikely to meet the 90% target, set by the Welsh Government[1] which states *'90% of all Consultants have an agreed job plan in place at all times by 30 September 2025.'* We note this has been an issue on the Medical Workforce Group (MWG) agenda since the 8 July 2025 meeting but can find no other routine reporting on this specific target.
- The Health Board has not published the draft policy/procedure since our review as it awaited an all-Wales guide, which has yet to materialise. The Health Board policy/procedure is critical to ensure internal control in job planning is consistent across the Health Board, and to ensure compliance with the nationally agreed contract.
- There has been no formal review of first and second sign-off within the EJob Plan system, consequently it remains unclear whether the correct officers are reviewing and approving job plans. Further, test and generic details remain in the 'live' system, exposing the system to risk of inaccurate reporting.

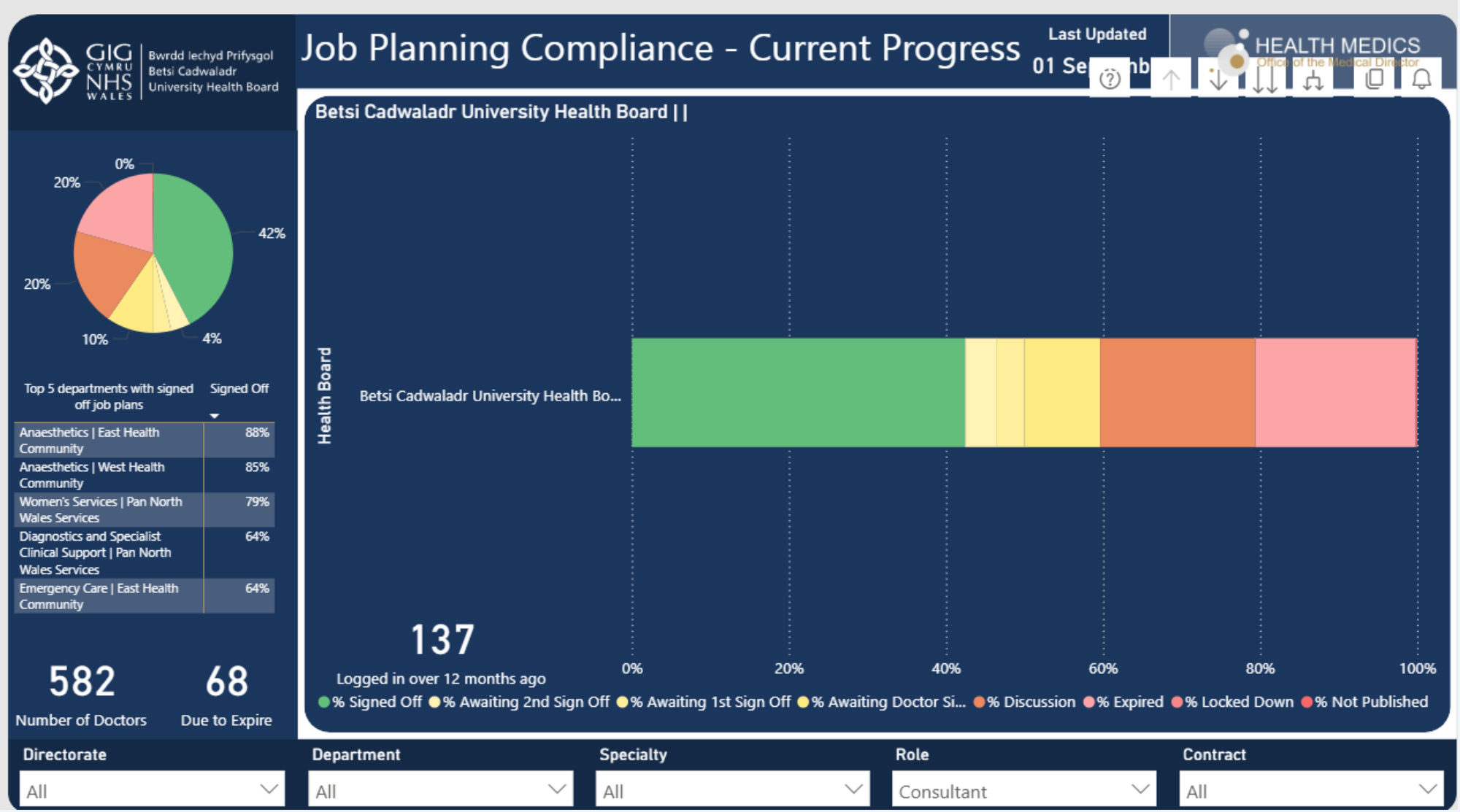
[1] Welsh Government Remit Letter to the NHS Wales Executive 2025-26 – Workforce Productivity reference 6.4 (page 22) performanceandimprovement.nhs.wales/about-us/key-documents/annual-plans-and-remit-letters/welsh-governement-remit-letter-to-the-nhs-executive-2025-26/

- No directorate or specialty service objectives have been recorded or documented, which may affect effective service transformation and ongoing improvement – this represents significant oversight by management and should be embedded in every job plan review.
- Reporting on medical and dental job plan performance is inadequate; whilst recognising the MWG has a specific agenda item, and hyperlinks to the dashboard are shared widely by the Office of the Medical Director's Job Planning team, there is no evident reporting to the Health Board's People and Culture Committee or local People & Culture meeting via the respective People Operations Report.

We received a reply to the request for information from Central, East and West IHCs and Women's Services. Again, we must report that Mental Health and Learning Disabilities, Cancer Services and North Wales Managed Clinical Services did not reply to our request for evidence, required by Standing Financial Instruction 3.2.2.

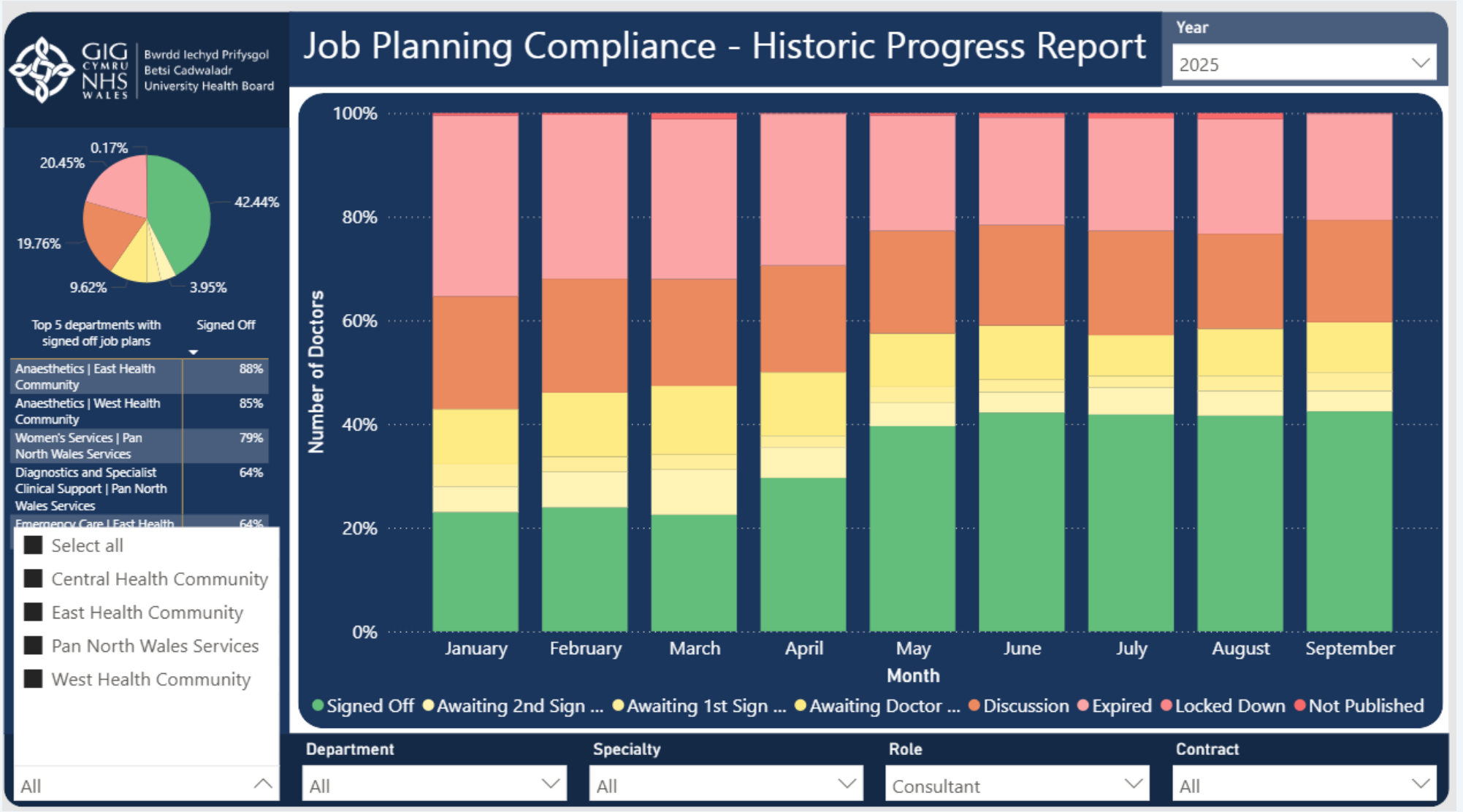
Health Board Consultant Job Plan data - At a Glance

Image 1: Health Board Job Plan dashboard compliance 1 September 2025 – Consultant Role



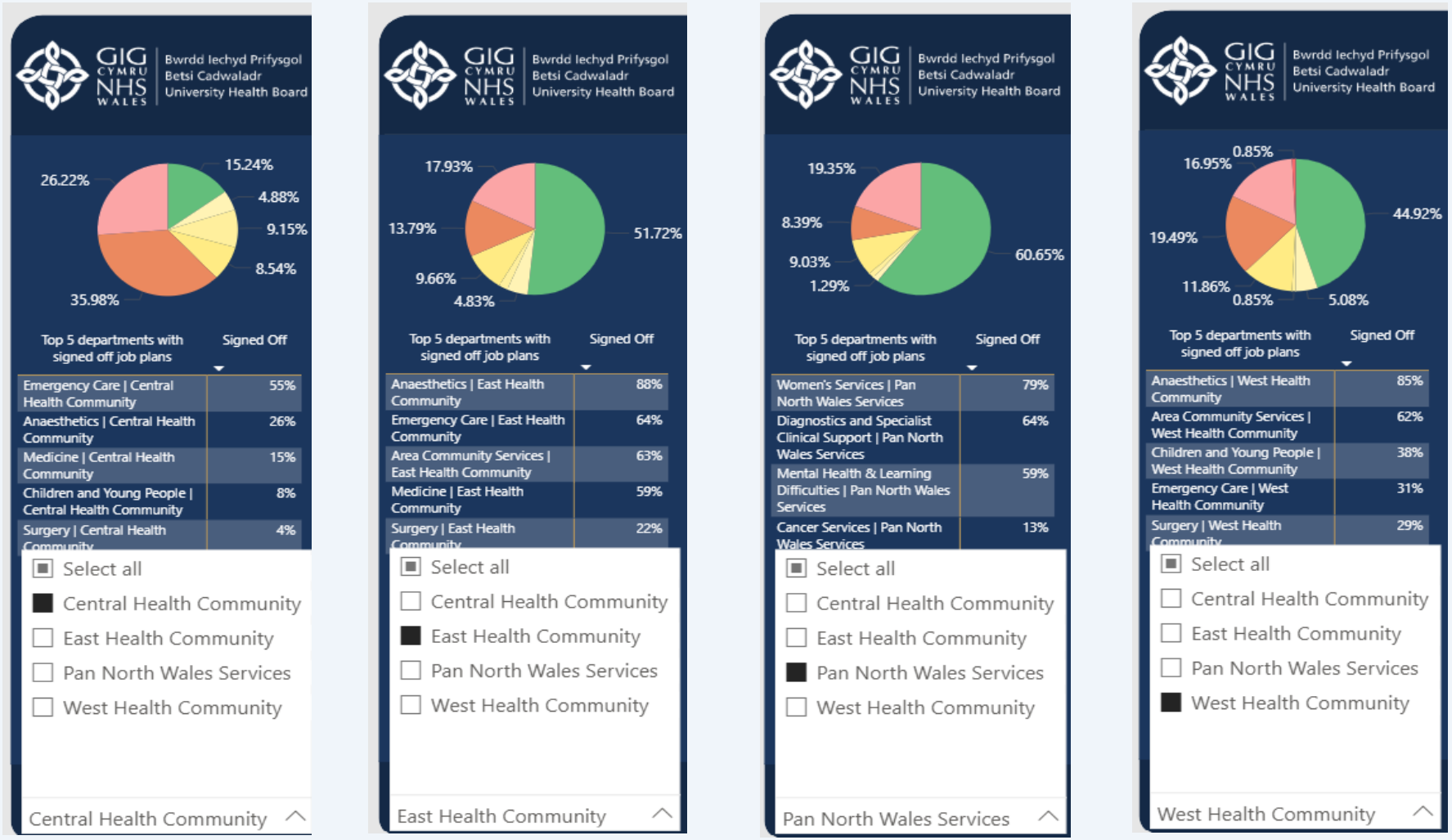
Source: Health Board Job Plan Progress Dashboard 1 September 2025 16:17 Job Planning Compliance - Current Progress - Power BI

Image 2: Health Board Job Plan dashboard compliance 1 January to 1 September 2025 – Consultant Role in total and by Service



Source: Health Board Job Plan Progress Dashboard 1 September 2025 16:22 [Job Planning Compliance - Historic Progress - Power BI]

Image 3: Health Board Job Plan dashboard compliance 1 January to 1 September 2025 – Consultant Role by Service



Source: Health Board Job Plan Progress Dashboard 1 September 2025 16:22 Job Planning Compliance - Historic Progress - Power BI

Status of Previously Agreed Recommendation

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.				
1.	**Health Board Policy** The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011. Limited training is provided to all individuals involved in the job plan process.	Interim Medical Director 31 May 2025	**High**	**Current status – Not implemented** **Finding** The Health Board does not have an agreed Policy/Standard Operating Procedure in place to support management, and consultants fulfil expected compliance with the nationally agreed Consultant Contract. This remains a significant gap in internal control. We are advised that the Health Board has not progressed with its own draft policy/procedure as it waited for nationally developed best practice guidance which has not materialised. With no policy or standard operating procedure in place, we recognise the decision not to develop a Health Board wide training needs analysis. We have seen evidence where the Job Planning Specialist undertakes ad-hoc training and note this as good practice. **Revised Action, Responsibility and Timescale** The final draft of the BCU job planning policy (JPP) (co-authored with LNC / BMA) is to be discussed by Executive Medical Director at JLNC meeting on 14 October 2025. It is anticipated that final approval of the JPP will be secured by December 2025. However, this is a re-iteration of current principles and processes and thus implementation can continue as this goes through final sign off. A training needs analysis has identified 3 core staff groups, with trajectory for completion of training: 1. All medical staff in leadership position with operational responsibility will require training against the JPP. Training

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				to be completed for all within 2 months of JPP approval. Training will be delivered as a series of roadshows, which are planned to be delivered jointly by senior medical leaders and LNC colleagues. 2. Operational staff who will be supporting team and individual job plan meetings. These staff will require both training re JPP and the use of Allocate system. Completion of training re JPP within 2 months of sign off. Allocate training 6 months from date of submission of this paper i.e., March 2026 3. Medical staff who are required to have annual job plan in place. Training for this staff group will be managed via 2 processes (a) alongside the medical leadership team, anticipated compliance with training will be 60% within 2 months of JPP approval (b) linked to the date of their next job plan for those who have not attended initial 'roadshow' training events. Compliance of above 95% training would be achieved within 1 year of JPP approval dependant on distribution of individual job planning meeting dates. The JPP starts to detail core SPA activity, and possible tariff for additional SPA over core. Expectation is that evidence is provided at job plans for all SPA (and DCC) to secure the SPA payment. Standard of evidence will need to be a focus of training for all staff Compliance is tracked locally by Medical Directors / Clinical Directors and Directorate General Managers (or equivalent). Rates will be monitored via local People and Culture and local workforce groups. At Health Board level compliance will be reported via Medical Workforce Group, highlighting any departments of concern. **Executive Medical Director** **31 May 2026**
3.	**EJob Plan First and second sign-off**	Interim Medical	**High**	**Current status – Not implemented**

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	Through a review of first and second sign off details in the EJob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system. This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.	Director 30 April 2025		**Finding** There has been no formal review of first and second sign-off within the EJob Plan system. We were advised that Women's Services have undertaken a review of their sign-off details but have not corroborated this. Our review of the information has again identified test and generic details in the system that compromises data quality. Only the training module should be used for test data to preserve the integrity of the live system. **Revised Action, Responsibility and Timescale** Process for sign off included in policy, including timeframes for sign off at each stage. The training programs will ensure staff are aware of the process and time to sign off for each stage. A previous 'distant' sign off process has been approved by Local Negotiating Committee (LNC) and will continue within the revised JPP. However, Allocate does not currently facilitate 'distant' sign off. Health Medics team in discussion to ensure this is possible and that any test data is removed from live system. We currently have not received a timeframe for an upgrade of Allocate to facilitate this process. If Allocate are unable to provide the Health Board will need to find a 'work around' which would be in place within 6 months i.e., April 2026. **Executive Medical Director** **30 April 2026**
Objective 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.				
5.	**Job Plan annual review** Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data.	Interim Medical Director and Deputy Director of People 30 April 2025	**High**	**Current status – Not implemented** **Finding** Our review of Health Board data as of 1 September 2025 showed overall compliance of 42% (Image 1 above) where job plans have been agreed and signed off.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.			We have been advised that review dates have not been amended to reflect the individual's incremental date. It remains unclear how the Health Board will meet the 90% target of in-date job plans by 30 September 2025, set by Welsh Government. **Revised Action, Responsibility and Timescale** All Wales medical T&Cs advise that all relevant staff should have an in date and signed off job plan at least annually, with updated job plans if there is any significant change to the doctors working pattern or responsibility. This is clearly outlined in the draft policy. It will mean that job plans may not align to the doctor's incremental date. It is also anticipated that any change in operational structure recommended by Foundations for the Future cultural review may impact a number of individual job plan reviews. Monitoring via Power BI in place and allows for drill down by team (but not to individual staff level). The Health Board acknowledges that the target of 90% by September 2025 has not been met. This is primarily due to the delay with agreeing a revised JPP. The proposed trajectory for compliance is 50% end Q3, 75% end Q4, >90% by end Q1. This trajectory will be signed off at the Medical Workforce Group 15 October 2025 Monitoring of compliance would be as above, via local processes and at HB level at Medical Workforce Group and People and Culture Committee. **Executive Medical Director and Deputy Director of People** **30 October 2025**
6.	**Directorate/Specialty objectives are explicit** There is a generic statement within the Service Outcomes section of job plans *"To ensure service and*	Interim Medical Director 30 April 2025	**High**	**Current status – Not implemented** **Finding**

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	job plan aligned to deliver CPG and wider BCU Strategic direction", (sic). The Service Outcomes section overall was either incomplete or noted *"During job plan discussions need to review this"*. From our review, we are unclear how management are approving job plans without expected service objectives. We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.			We reviewed a sample of one job plan from the three Integrated Health Communities and the four pan North Wales clinical directorates. We found four (57%) were in-date and current, however none had any directorate or specialty service objectives recorded. **Revised Action, Responsibility and Timescale** The draft JPP outlines importance of service demand / capacity discussion *prior* to an individual job plan timetabling meeting. This will identify service priorities to align at job plan meeting. Individuals PDP from appraisals will inform service and personal priorities and objective for the coming year. The need for service priorities to be clearly articulated and aligned within individual job plans will be a core expectation for the training program and roadshows. Compliance with this element will need to be monitored via a quality assurance process which is beyond current capability of PowerBI monitoring. A sustainable automated solution will be in place within 6 months *if DDaT colleagues have the capacity to prioritise this work* It is anticipated that implementation of any operational structure following Foundations for the Future review may impact on a need to review service priorities and alignments. **Executive Medical Director** **30 April 2026**
Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.				
7.	**Evidencing achievement of the Board objectives** Whilst there were strategic goals detailed in the Board Outcomes section of the job plan, they did not reflect the current strategic objectives, and there were no	Interim Medical Director 30 April 2025	**High**	**Current status – Implemented** **Finding** The review of the seven job plans confirmed that all had the current Health Board objectives recorded. In addition,

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	measurable outcomes agreed from which it could be evidenced as being worked to/achieved.			we found that three included Ministerial Priorities, with two also recoding the Values and Behaviours Framework.
Objective 4: Completed job plans reconcile to system records and session payments are correct.				
8.	**Regular review of payments to agreed job plan commitments** 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 review or 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.	Deputy Director of People 30 April 2025	**High**	**Current status – Not implemented** **Finding** The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025 but have not corroborated this or requested sight of the draft dashboard. **Revised Action, Responsibility and Timescale** 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. **Deputy Director of People** **31 December 2025**
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** 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.	Deputy Director of People 30 April 2025	**High**	**Current status – Partially implemented** **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.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				We contacted the seven clinical service Directors to obtain details of their People and Culture meeting or to confirm where job plan performance and assurance was discussed. We received a reply for Centre, East and West IHCs and Women's Services but received no reply from Mental Health and Learning Disabilities, North Wales Managed Clinical Services or Cancer Services. We noted limited assurance reporting at a local level within IHC West on job planning. The West IHC Medical Director (Chair of the MWG) provided evidence of follow-up compliance with job plan completion to West operational leads. Women's Services hold monthly Centre, East and West Accountability Meetings where we noted job planning as an agenda item. We also noted a standing agenda item on the Clinical Directors bi-monthly meeting. Through our review of operational People and Culture meetings provided to us, we were unable to find any reference in the People Operations Report or any specific reporting on consultant job plan performance. **Revised Action, Responsibility and Timescale** 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. **Deputy Director of People** **31 March 2026**

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
11.	**Medical Workforce Group & People & Culture Executive Delivery Group (EDG)** The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it *"….will receive regular reports (on job plans) as per its Cycle of Business"* but we have been unable to verify they have actually received any reports for assurance recently. Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024). The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.	Deputy Director of People 30 April 2025	**High**	**Current status – Not implemented** **Finding** There is no evident reporting on consultant job plan performance to the Health Board's People and Culture Committee through the People Operations Report. We note a verbal update was provided to the Committee by the Interim Executive Medical Director at the 14 August 2025 meeting (Agenda Item PC25/82). The People & Culture Executive Delivery Group is still yet to be re-established. Consequently, assurance reporting from the Medical Workforce Group is not subject to any scrutiny or assurance to the Executive Committee and/or the Health Board People & Culture Committee. The Medical Workforce Group (MWG) is meeting regularly although we note its Terms of Reference require review as there has been a change in Chair that has not been reflected. A review of minutes has identified regular discussion on job plan performance. Of the minutes viewed, we noted the June 2025 meeting recorded *"action...to recirculate the Power BI link to ensure all members could access and monitor their compliance data."*. We note in July and August 2025 meetings a focus on the Welsh Government set target of 90% completed job plans by 30 September 2025 with the draft August 2025 minutes noting *"Current compliance was reported to be significantly below this target, prompting concern and a renewed focus on improvement."* **Revised Action, Responsibility and Timescale** Medical Workforce Group (MWG) is now chaired by an experienced medical leader who has developed Health Board Job Planning Policy in collaboration with LNC. It is the place where relevant care groups are held to account and where implementation of JP policy and relevant procedures will be monitored.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				MWG will report to People and Culture Executive Delivery Group and thus to People and Culture Committee **Deputy Director of People** **31 October 2025**

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

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

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