Bundle Audit Committee 30 June 2022

0 14:00 - OPENING BUSINESS - OPEN SESSION

1 14:01 - AC22.22: Apologies for Absence

Apologies received from:
Nick Lyons, Executive Medical Director (Conrad Wareham, Interim Deputy Medical Director in attendance).
Andrew Doughton and Fflur Jones - Audit Wales (Matthew Edwards and Michelle Phoenix in attendance).

2 14:02 - AC22.23: Declarations of Interest

3 14:03 - AC22.24: Procedural Matters - Minutes of Previous Meeting, Summary Action Log and Breach Log - Molly Marcu

The Audit Committee is asked to:-
1. confirm the Minutes of the last meeting of the Committee held in open session on 15th March 2022 as a correct record and to discuss any matter arising;
2. review the Summary Action Log; and
3. note the details of breaches (in terms of publication of Board/Committee papers) to the Standing Orders.

AC22.24a: Draft Public Minutes_Audit Committee_March22_V0.02.docx

AC22.24b: Audit Committee Public Action Log_March 2022.docx

AC22.24c Breach Log Audit June 2022 meeting.docx

4 14:08 - AC22.25: Report on issues discussed in previous Private Committee Session - Molly Marcu

The Audit Committee is asked to note the report.

AC22.25: Private Session Items Reported in Public_June_22.docx

5 14:09 - AC22.26: Executive Director Verbal Briefing on Financial Accounts - Sue Hill

At its meeting on 26th May 2022, the Board delegated authority for approval of the 2021/22 annual financial statements to the Audit Committee.

6 14:19 - AC22.27: External Audit - Audit Wales

The Audit Committee is requested to:
• Receive and discuss the programme update.
• Approve the Annual Plan

AC22.27a: External Audit - Audit Wales Reports coversheet.docx

AC22.27b: BCU AC Update June 2022.pdf

AC22.27c: Final BCU Audit Plan 2022.pdf

7 14:29 - AC22.28: Internal Audit Reports - Dave Harries

The Audit Committee is asked to:-
1. receive the progress report and note and receive the Head of Internal Audit opinion and annual report for 2021/22; and
2. approve the change to issuing draft reports and remove issuing discussion draft reports.
3. note and receive the following Limited Assurance Reports:
Waiting List Management
Clinical Audit
Nursing Roster Management - Introduction of e-timesheets for Agency staff
On-call arrangements
Business continuity

AC22.28a: BCUHB Internal Audit Committee cover sheet June 2022.docx

AC22.28b: BCUHB Audit Committee progress report June 2022.docx

AC22.28c: Final Internal Audit report - Waiting list management.pdf

AC22.28d: Final Internal Audit report - Clinical Audit.pdf

AC22.28e: Nursing Roster Management Introduction of E Timesheets for Agency Staff.pdf

AC22.28f: Final Internal Audit Report - On-call arrangements.pdf

AC22.28g: Final Internal Audit Report - Business Continuity Plans.pdf

AC22.28h: BCUHB - Opinion Annual Report 21-22 v1.docx

8 14:49 - AC22.29: Claims Report Public Session - Matt Joyes

The Audit Committee is asked to receive the report

AC22.29: Claims Over 50k Spend Closed Q4 2021-22 - Public.docx

9 14:54 - AC22.30: Clinical Audit Plan - Verbal Briefing

10 15:09 - AC22.31: Risk Management Strategy

The Audit Committee is asked to:
• Note and endorse the objectives of the Risk Management Strategy
• Note and endorse the Risk Management Strategy for Board Approval in July 2022

AC22.31a: Risk Strategy cover sheet.docx

AC22.31b: Draft Risk Management Strategy 230622.docx

AC22.31c: EqIA RM Strategy 2022 - V.2.docx

11 15:19 - AC22.32: Chair's Assurance Report - Risk Management Group

The Audit Committee is requested to note this report.

AC22.32: Chair's Assurance Report- Risk Management Group - v2.docx

12 15:29 - AC22.33: Corporate Risk Register

The Committee is asked to:
Review, scrutinise and discuss the report.
Gain assurance that the Health Board`s Risk Management arrangements are effective and fit for purpose.

AC22.33a: CRR Coversheet.docx

AC22.33b: Appendix 1 - Audit Committee Full CRR.pdf

AC22.33c: Appendix 2 - Full List Corporate Risks V.9.pdf

AC22.33d: Appendix 3 - Risk Key Field Guidance V2-Final.pdf

13 15:39 - AC22.34: Operational SORD - Nigel McCann

The Audit Committee is asked to:
1. Note that all narrative in red is where additions or amendments have been made from the SORD approved by the Audit Committee in March 2022.
2. Note the addition and clarity of the flow of Delegated Matters through the Board & Executive to the Operational front-line (as per the 3 columns within Schedule 1 of the SORD)
3. Within Table B2, recognise that this will be populated as and when the next tier of structures are agreed, either in the IHC, other Division or Support Function, as such this SORD will continue to be updated during the next 6 to 12 months.
4. Note that implementation locally (in the first instance) will be through the Chief Finance Officers (CFO's) working with their IHC/ Divisional Management Teams; as this is largely about Financial Limits & Controls it is logical for it to be via the CFO's. This will be implemented as part of the overall Governance & Assurance Framework.
5. Endorse the attached SORD and approach, ahead of Board approval in July 2022
6. Endorse the continued development of the next level of detail (as posts are agreed within the structures) ready for implementation alongside the Operating Model go-live.

AC22.34a: June 2022 Audit Committee - Update on the SORD.docx

AC22.34b: Master SoRD - New Operating Model V6.docx

14 15:49 - AC22.35: Issues of significance for reporting to the Board

Members are asked to raise any issues of significance for reporting to Board via the Chair's Assurance Report.

15 15:50 - AC22.36: Date of next meeting - 27th September 2022

16 15:50 - AC22.37: Move into closed session

AUDIT COMMITTEE PUBLIC MEETING

Draft Minutes of the Meeting Held on 15.03.22

Via Microsoft Teams - the Health Board has determined that the public are excluded from physically attending the Committee's meeting in order to protect public health during the pandemic.

Present	
Richard Medwyn Hughes	Independent Member (Chair)
Jacqueline Hughes	Independent Member
Lyn Meadows	Independent Member

In Attendance	
Andrew Doughton	Audit Manager, Audit Wales
Simon Evans-Evans	Interim Director of Governance
Dave Harries	Head of Internal Audit, NWSSP
Sue Hill	Executive Director of Finance
Nicola Jones	Acting Deputy Head of Internal Audit, NWSSP
Fflur Jones	Performance Audit Lead, Audit Wales
Matt Joyes	Acting Associate Director Of Quality, Patient Safety and Experience (for Minute AC22.08).
Molly Marcu	Interim Board Secretary
Simon Monkhouse	Finance Audit Lead, Audit Wales
Chris Stockport	Executive Director Transformation, Strategic Planning and Commissioning (for Minutes AC22.10 and AC22.11)
Conrad Wareham	Interim Deputy Medical Director (for Minute AC22.06)
Bethan Wassell	Statutory Compliance, Governance & Policy Manager
Tim Woodhead	Finance Director of Operational Services
Karl Woodward	Head of Counter Fraud (for Minute AC22.09)

Agenda Item	Action
AC22.01: Opening Business and Apologies for Absence. The Chair welcomed Members and attendees to the meeting. Members agreed that the meeting would be recorded for administrative/minuting purposes on the understanding that it would be deleted once the minutes were finalised / in accordance with the all Wales retention period. Apologies received from: Richard Micklewright, Independent MemberNick Lyons, Executive Medical Director Louise Brereton, Board Secretary. Gill Harris, Executive Director of Nursing & Midwifery / Deputy Chief Executive.	
AC22.02: Declarations of Interest. No declarations of interest were made at the meeting.	
AC22.03: Procedural Matters. The Chair presented the items and Members noted the following points: **AC22.03.01:** The Chair highlighted action 5 from the Summary Action Log (pertaining to the escalation of governance issues at YGC). Whilst Members acknowledged that the YGC Governance Concern had been escalated via the Chair's Assurance Report to the January meeting of the Health Board, there remained an outstanding question as to the outcome and subsequent actions to be taken. It was important that the Audit Committee obtained appropriate responses to matters escalated. The Interim Board Secretary suggested that the matter be reiterated within the next Chair's Assurance Report and agreed to raise with both the Chairman and the Executive Team prior to the next meeting of the Board. **AC22.03.02:** Members proceeded to review the Breach Log. Queries were raised as to the purpose/content of the report and whether this was an accurate reflection of the number of breaches, i.e. the process whereby breaches were recorded and whether there was adequate oversight. A reliance on self-referrals from Committee secretariats was not considered sufficiently robust. **AC22.03.03:** An Independent Member further noted that the purpose of the Breach Log should be to identify themes, areas of concern and minimise their occurrence. The Executive Director of Finance concurred and suggested that the length of delay and the reason for the breach should also be recorded. Whilst there may be instances where the	MM

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requirement for up to date information was of paramount importance and would justify a late submission (subject to prior agreement), such as Covid-19 data for example, there were other instances that were not acceptable. An Independent Member agreed and noted that this issue had also been raised by the Health Board Vice Chair (and Chair of the Quality, Safety & Experience Committee). The Executive Director of Finance advised that the issue of late papers had be raised with the Executive Team and that the Chief Executive had reiterated that Committee papers were the responsibility of the identified Committee lead Executive. The Head of Internal Audit advised Members that a review of breaches was included within the Internal Audit Plan, Q1 2022/23. **AC22.03.04:** The Executive Director of Finance advised that they would relay the Audit Committee Member's concerns back to the Executive Team and the Interim Board Secretary agreed that the process and report content would be reviewed for submission to the next meeting. **RESOLVED:** That the Audit Committee; • approve the minutes of the meeting of the 14th of December 2021 as an accurate record; and • reviewed and noted the Public Summary Action Log: and • reviewed and noted the Breach Log; and • approve the proposed Committee Cycle of Business for 2022/23.	MM/SH
AC22.04: Issues Discussed in Previous Private Committee Session. **RESOLVED:** That the report on issues discussed in the previous Private Committee session be noted.	
AC22.05: Chair's Assurance Report : Risk Management Group The Interim Director of Governance presented the Risk Management Group Chair's report on behalf of the Executive Medical Director. **AC22.05.01:** Members observed that the quality of the paper had improved. The paper was clear and informative. The Chair queried whether there was an increase in 'deep dives' in comparison to previous activity. The Interim Director of Governance advised that the number was consistent but there was an increase in discussions around clinical risk, which had proven to be very useful. **AC22.05.02:** An Independent Member noted the inclusion of emerging risks and highlighted the benefits of horizon scanning. Members sought clarity on how the relevant Committees were sighted on this. The Interim Director of Governance advised that this would be dependent on the scoring. The risk must be qualified prior to submission and it may be the	

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case that the risk should be managed locally/operationally as a Tier 2. An Independent Member further queried how this related to the Health Board's Key Performance Indicators (KPIs) and oversight from the Performance team. The Interim Director of Governance advised that regular meetings between the Corporate Risk, Performance team and the Office of the Board Secretary (OBS) were in place to ensure sufficient oversight and communication. **AC22.05.03:** Members noted the *Capacity of the Emergency Department* risk and asked for further information. The Interim Director of Governance advised that this was a tier 2 risk. However, given the occurrence across the three sites, consideration would be given to escalating into a single tier 1 risk. The Interim Board Secretary further clarified that the lost to follow up risk had been identified as a result of consolidating a few associated risks (that were not necessarily tier 1 level) as well as the limited assurance audit opinion on waiting list management, which highlighted some data quality issues. Work was underway to ensure triangulation of information (as part of the joint meetings between the Office of the Board Secretary and Risk Team) and would be taken in to account as part of the Board Assurance Framework (BAF) update. There was a specific risk relating to urgent care on the BAF, and this was updated to include capacity gaps in the Emergency Department as gaps in assurance . **RESOLVED:** That the Audit Committee noted and received the Chair's Assurance Report: Risk Management Group	
AC22.06: Board Assurance Framework and Clinical Audit Plan Verbal Update **AC22.06.01:** The Interim Deputy Medical Director joined the meeting and provided a verbal update on the Clinical Audit programme for 2022/23. The pandemic, alongside staffing vacancies, had significantly affected progress. However, the intention was for the plan to be submitted to the May 2022 meeting of the Quality, Safety & Experience (QSE) Committee in May 2022 and then the June 2022 meeting of the Audit Committee. The Chair expressed concern as to the flux in operational leadership / ownership and observed that both the Tier 1 and Tier 2 audits should be in place, this was a serious concern for the Committee. The Chair further noted that Audit Wales had similarly expressed concern as to the Health Board's lack of a plan. The Interim Board Secretary advised Members that a draft plan had been received by the Clinical Effective Group but required further refinement, specifically in relation to alignment with significant clinical risks. **AC22.06.02:** The Interim Board Secretary proceeded to provide Members with an overview of the work underway to refresh the BAF. All 21 risks had been reviewed individually with the responsible Executive	

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and a proposal was in development to determine which risks remained relevant. A Workshop was planned for April 2022. Members concurred that there was a requirement to align the BAF with the Health Board's risk appetite and Integrated Medium Term Plan (IMTP). (The Interim Deputy Medical Director left the meeting). **RESOLVED:** That the Audit Committee noted the Board Assurance Framework and Clinical Audit Plan Verbal Update.	
AC22.07: Standing Orders And changes to the SORD. **AC22.07.01:** The Interim Board Secretary presented the item and advised that the operational arrangements would remain extant as necessary pending the implementation of the new operating Model, wherein any further changes would again be submitted for review and endorsement to the Audit Committee. **AC22.07.02:** An Independent Member drew the Committees attention to the proposal that the Performance, Finance and Investment Committee (PFIG) was delegated an authority limit of £850,000k for signatory of business cases. The Interim Board Secretary advised Members that this proposal was to enable the Board to focus on strategic matters with appropriate delegation to a Committee. It would also reduce the number of, and the risks associated with, the requirement to take Chair's Action on decisions. The Independent Member noted this though suggested that further discussion, alongside the Auditors, was required. **AC22.07.03:** The Head of Internal Audit agreed further discussion was necessary. There was a risk that in providing a Committee with a delegated limit, it would become involved in operational decision-making. Whilst it was accepted that this might streamline decision making, it did provide for possible conflict and raised the question as to the Executive role in decision making. There was ambiguity as to how this related to the delegated limit of the Chief Executive. The Interim Board Secretary noted that their understanding was that the Chief Executive was unable to sign off a business plan independently / in isolation but would confirm and report back to the Committee. **AC22.07.04:** An Independent Member agreed and queried the position of the Charitable Funds Committee, which had the ability to grant monies. Further clarity was required. The Interim Board Secretary clarified that this particular aspect of the SORD had not been amended from the previous version, but would be incorporated into a further review ahead of Board.	MM MM MM

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AC22.07.05: The Executive Director of Finance noted that by failing to delegate appropriately, this could inhibit the effectiveness of the Board and its strategic objectives. It was important to obtain the right level of materiality. The Interim Director of Governance concurred with the importance to streamline decision-making and a discussion ensued as to the process nationally. The Interim Board Secretary advised that this was best practice that had been discussed with Welsh Government and was pending confirmation on whether this could be standardised on an all Wales basis. **AC22.07.06:** The Finance Director of Operational Services noted that the Health Board was in the process of approving the new Operating Model. There would be a requirement for further revisions to the SORD to reflect new operational management structures. **AC22.07.07:** The Interim Director of Governance drew Members attention to section 2a, *calling meeting of the LHB*. It was suggested that this should be delegated to the Vice Chair rather than the Board Secretary. The Interim Board Secretary and the Finance Director of Operational Services agreed to discuss and ensure this reflected best current / practice. **AC22.07.08:** Members concluded by agreeing to endorse the proposals subject to further discussion as to Committee delegated limits and the approval of the proposed new Operating Model by the Board **RESOLVED:** That the Audit Committee noted and endorsed the updated SORD for Board approval, subject to the provisions/actions noted above.	MM / TW
AC22.08: Schedule of Financial Claims (Public) **AC22.08.01:** The Acting Associate Director Of Quality, Patient Safety and Experience joined the meeting and presented the item. Members noted that the report had been summarised / anonymised to protect patient identifiable information. The Acting Associate Director Of Quality, Patient Safety and Experience left the meeting. **RESOLVED:** That the Audit Committee received and noted the report.	
AC22.09: Policies for Consent **AC22.09.01:** The Interim Board Secretary provided members with an overview of the revised Standards of Business Conduct Policy. An	

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Independent Member sought reassurance that all of the findings / recommendations from the recent Internal Audit Limited Assurance report had been considered and addressed. The Interim Board Secretary confirmed this to be correct and drew Members attention to process improvements that would support the implementation of, and compliance with, the revised policy. Of particular note was the importance of internal reporting frequency and staffing resilience with the OBS to ensure the associated processes were embedded. Members further noted that the requirement to appropriately declare interests, gifts and hospitality was a provision within the all Wales NHS employment contract. The Head of Counter Fraud confirmed that the Counter Fraud team had been consulted on the review and provided comments on the revised policy. **AC22.09.02:** An Independent Member noted the reference to an Appendix within the coversheet report that was not included. The Interim Board Secretary advised that this was a summary of the Internal Audit recommendations and would circulate this outside of the Committee. **AC22.09.03:** Members agreed that it was extremely important that all employees were fully appraised of their responsibilities and the need to declare interests, gifts and hospitality. The subject area could be complex and the policy was lengthy. The Interim Board Secretary advised that a meeting with the Corporate Communications team was scheduled and a plan for a 'Frequently Asked Questions' summary was in development. In addition, the current system provided examples of different types of Interests and explanations of key terms such as 'controlling interest'. The Chair further noted that simplicity in the process was also important to ensure staff engagement. The system should be as user friendly and easy to navigate as possible to encourage declarations. **AC22.09.04:** The Head of Internal Audit observed that there remained an overlap between the Standards of Business Conduct Policy and the *WP6 Code of Conduct (Disciplinary Rules and Standards of behaviour).* There may be an opportunity to merge both documents that would aid employee awareness / understanding of the associated responsibilities and the potential repercussions of non-compliance. **AC22.09.05:** An Independent Member highlighted the importance of providing standard narrative within all Health Board Written control Documents to ensure all staff groups and workers were incorporated into the scope of applicability. **RESOLVED:** That the Audit Committee approve the: • Periodic review of the Standards of Business Conduct Policy and; • Periodic review of the Counter Fraud Policy	MM BW

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AC22.10: Internal Audit **AC22.10.1:** The Executive Director Transformation, Strategic Planning and Commissioning Joined the meeting. The Acting Deputy Head of Internal Audit presented the Progress Report. Of particular note was the KPI decline detailed in table 3, with regard to report turnaround. The timely issue of Management Responses was a critical factor to ensure the Internal Audit Opinion could be delivered in time. **AC22.10.2:** An Independent Member noted that this was a concern for the Committee and queried as to the reports awaiting Executive approval. The Deputy Head of Internal Audit noted that one delay had been incurred due to the initial response being recalled – the Executive and Operational leads were not satisfied with their original submission noting that organisational change had meant that it was no longer appropriate. The Independent Member accepted that whilst still a concern, it was equally important that any Management Responses were realistic and fully addressed the findings to deliver improvements. **AC22.10.3:** The Head of Internal Audit affirmed the importance of timely Management Response. Delays inevitably disrupted planned work and it would be necessary to formally write to the Chief Executive to highlight concerns. However, the Head of Internal Audit did wish to formally record their thanks to both the Interim Board Secretary and the Executive Director Transformation, Strategic Planning and Commissioning for their support in clearing their final reports. The Chair noted the comments and agreed that the concerns should be flagged to the Executive team. **AC22.10.4:** The Executive Director Transformation, Strategic Planning and Commissioning noted the concerns and offered apologies for the associated delays. The Executive Director Transformation, Strategic Planning and Commissioning went on to provide Members with an overview of Integrated Service Boards and the associated challenges and variations. Members agreed that the report was timely and that the outcomes and learning should be integrated in to the implementation of the new Operating Model. **AC22.10.5:** Members proceeded to discuss the Standards of Business Conduct limited assurance review. The Interim Board Secretary highlighted the specific risks associated with non-compliance. In addition to breaching applicable legislation, there was also a risk of reputational damage as well as incomplete/inaccurate register of interests and related party transactions disclosure within the 2021/22 annual accounts. **AC22.10.6:** As noted earlier on in the meeting, the Standards of Business Conduct Policy had been reviewed. Members further noted that the Health Board was exploring procurement options for a new system that would provide superior monitoring and reporting	MM

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functionality. The intention was to have this implemented by the 1st of April. Members were informed that one of the forthcoming priorities was gifts and hospitality, as the volume of declarations were significantly lower than expected, for an organisation of it size. The Interim Board Secretary concluded by emphasising the importance of devolved ownership via designated governance leads. There would be a requirement to review and refresh those identified to ensure operational ownership and management in addition to Corporate oversight. **AC22.10.7:** The Head of Internal Audit concurred with the concerns raised both by the review and by Members during the Policy review discussion. There were concerns as to the low number of declarations that suggested that gifts & hospitality were not being routinely reported. The Finance Audit Lead, Audit Wales further added that this had also proven to be a concern during the 2020/21 financial audit of accounts and would likely be an area of risk within the ISA260 report for the current financial year. **AC22.10.08:** The Chair reiterated their previous comments and stressed again that there was a need to ensure that the process was made as simple as possible. The existing system could be cumbersome and the improvements would be welcome. **AC22.10.09:** The Chair drew Members attention back to the Progress report in order to raise the importance of being able to evidence improvements given the Health Boards position and relatively recent removal from Special Measures. Whilst both the Learning Lessons and the Targeted Intervention (TI) review had returned a 'reasonable' assurance rating, there were still areas that required addressing. Notwithstanding a 'reasonable assurance' rating, it was of high importance that the Chief Executive was aware of any areas that required further improvement. An Independent Member noted that the Terms of Reference for the TI Steering Groups had been raised at the March Board meeting. The Interim Director of Governance clarified that the TI Steering Group Chair's reports had been submitted to the Board from the last two meetings. The Chair acknowledged this, and reiterated the requirement to reaffirm the Audit Committee's concerns to include any outstanding risks associated with the two reviews as well as the quality and timeliness of Management Responses. **RESOLVED:** That the Audit Committee: • Received and discussed the Internal Audit Progress Report and; • Reviewed and approved the Internal Audit Plan and; • Received and discussed the Limited Assurance Reports.	MM

Agenda Item	Action
AC22.11: Audit Wales **AC22.11.01**: The Finance Audit Lead, Audit Wales provided an overview on the Financial Audit work undertaken to date. The majority of the information had been provided by the BCUHB Finance team and Auditors were working their way through. The intention was that the Accounts would be submitted on the 15th of June 2022 **AC22.11.02**: The Audit Manager, Audit Wales advised Members that the normal cycle of business would have included the submission of the Audit Wales Plan. However, this had not yet been finalised and there would be a requirement to circulate outside of the meeting. The Audit Manager, Audit Wales concluded by advising that they would circulate a link (Consultations | Audit Wales) to a consultation that was seeking views on the Auditor General's Work Programme. **AC22.11.03**: Members proceed to discuss the Quality Governance Review and were pleased to note a proactive approach to quality a quality improvement strategy. Whilst there were areas for improvement, BCUHB were not an outlier in this respect. The Audit Manager, Audit Wales concluded by expressing thanks to those involved in the review. **AC22.11.04**: An Independent Member observed that the report was extremely comprehensive and very important, with 'quality' being one of the core values of healthcare. However, there was a question as to the quality of the Management Response. The Independent Member observed that many of the recommendations were listed as 'closed' with limited information or explanation and did not fully address the recommendation. The Independent Member queried whether the Management Responses were being completed by the right people and whether sufficient time was being taken in order to provide quality responses. **AC22.11.05**: The Executive Director of Finance agreed with the observation - it was also important that responsible authors were afforded sufficient time to fully document the measures taken by the Health Board in addressing improvements. **AC22.11.06**: The Chair expressed that it was extremely disappointing to note that an adequate response had not been provided. The Interim Board Secretary agreed and suggested that the process be reviewed and enhanced in line with the three lines of defence model. Members agreed that this would be a useful measure to mitigate similar reoccurrences but reiterated that action was required for the existing report. The Interim Board Secretary agreed to take the Committee comments back to the Executive team and oversee the revision of the report's management responses.	MM

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AC22.11.07: The Audit Manager, Audit Wales concluded by providing Members with an overview of the Commissioning Care Home Placements reports. Members noted that the Public Accounts Committee may consider the issue at a future date. Members were pleased to note that the coordinated Management Response submitted by the Health Board and local authorities had been well received by Audit Wales. **RESOLVED:** That the Audit Committee receive and discussed; • The Auditor General's Progress Report and; • The review of Quality Governance and; • The Commissioning Older People's Care Home Placements report and; • Commissioning Care Home Placements, BCUHB Management Response.	
AC22.12: Issues of Significance for reporting to Board There were no new matters of significant to report to the Board. Members agreed to escalate to the Chief Executive the matter of delays in management responses to internal audit reviews, resulting in a decline in the response rate 43%. **RESOLVED:** That the Chair of the Audit Committee prepare the Chair's Assurance Report for submission to the Board	MM
AC22.13: Date of Next Meeting: 13/06/22	
AC22.14: Exclusion of Press and Public **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.	

BETSY CADWALADR UNIVERSITY HEALTH BOARD

PUBLIC AUDIT COMMITTEE MEETING

REPORT ON MATTERS ARISING

Matters arising including items from the meeting held on 15/03/22

Item No.	Minute ref. no	Action	Lead Director	Original Completion Target Date	Action Status	Revised Completion Date
1	**AC21.60: Performance Accountability Report (PAF)**	Review and build in the PAF into the mandatory framework.	Executive Director of Finance	December 2021	Ongoing The PAF is being incorporated into the accountability framework, which may be subject to change in line with the revised operating model.	June 2022
2	**AC21.60: Performance Accountability Report**	Review arrangement in place for holding corporate functions to account on the PAF, to align with the Divisions.	Executive Director of Finance	December 2021	The accountability framework schedule is being revised to include a corporate function review for the next round of quarterly meetings. It will be submitted to the Board as part of the assurance to support the Operating Model.	
3	**AC22.03.01: Escalation of concerns to Board.**	YGC Governance Limited Assurance Report and associated concerns had been escalated via the Chair's Assurance Report to the January meeting of the Health Board. Confirmation of process for formal acknowledgement / outcome.	Interim Board Secretary	June 2022	Completed, item incorporated within Board agenda for 30th of March confidential board meeting. In addition, criteria and approach agreed for escalation from Committee to Board	March 2022

Item No.	Minute ref. no	Action	Lead Director	Original Completion Target Date	Action Status	Revised Completion Date
4	**AC22.03.04: Breach Log**	Content and process for reporting late papers to be reviewed. Audit Committee concerns to be brought to the attention of the Executive Team.	Interim Board Secretary / Executive Director of Finance	June 2022	Completed, internal audit performance report revised to incorporate KPIs and aid more clarity about late reports. Revised report submitted to Executive Director meetings in March 2022	Close
5	**AC22.07.02: SORD and Committee delegated limits**	Further discussion required between IMs, Auditors, Board Secretary and Finance to be facilitated.	Interim Board Secretary	June 2022	Completed, and incorporated within revised SORD that was submitted to March Board meeting for approval	Close
6	**AC22.07.03. SORD - CEO delegated limit / single sign off of business cases**	Clarity required as to how this relates / integrates with proposal for PFIG delegated limit	Interim Board Secretary	June 2022	Completed, it was clarified that the CEO delegated limit does not extend to business cases	Close
7	**AC22.07.04: SORD - Charitable Funds Committee and delegated limit**	Confirmation on the position for the Charitable Funds Committee (ability to grant monies) and reference in SORD.	Interim Board Secretary	June 2022	Completed, Charitable Funds Committee left unrevised	Close
8	**AC22.07.07: SORD – ability to call a meeting of the LHB**	Query as to whether this should be detailed as the Vice Chair rather than the Board Secertary.	Interim Board Secretary and Finance Director of Operational Services	June 2022	Completed, it was determined that the SORD should remain the same, as whomever is occupying the role of Chair (in the absence of the chair, including the vice chair/alternative independent member) would be incorporated in the reference to Chair	Close
9	**AC22.09.05 – SoBC Policy Report**	Omitted appendix A detailed in coversheet to be circulated.	Interim Board Secretary	June 2022	Completed, recirculated after March Audit Committee meeting	Close
10	**AC22.09.05 – policy reviews.**	Standard wording to ensure all staff groups are provided for in the scope of documents.	Statutory Compliance Manager.	June 2022	Narrative drafted and shared with Staff Side Independent Member and WOD policies group. Finalisation required (WOD sign off) but	Close

Item No.	Minute ref. no	Action	Lead Director	Original Completion Target Date	Action Status	Revised Completion Date
					Corporate Policies team will now ensure all document scope includes '*employees and workers'* as a minimum.	
11	**AC22.10.3 – Internal Audit**	Importance of timely Management Response – concerns flagged to Exec team	Interim Board Secretary	June 2022	Completed, internal audit performance report revised to incorporate KPIs and aid more clarity about late reports. Revised report submitted to Executive Director meetings in March 2022	Close
12	**AC22.10.09 – Internal Audit**	Learning Lessons and the Targeted Intervention (TI) reviews to be brought to the attention of the CEO	Interim Board Secretary	June 2022	Completed in March 2022	Close
13	**AC22.11.06: - Audit Wales**	Quality Governance Review, Management Response to be reviewed by Execs	Interim Board Secretary	June 2022	Completed in April 2022, meeting held with Audit Wales and the Deputy CEO to revise the recommendations	Close

Audit Committee

June 2022

Record of Breaches of Publication of Committee Papers since last reported to Audit Committee, not in accordance with Standing Orders

Meeting Date	Body	Standard	Issue/Reason for Breach	Details of papers
20.01.22	Health Board	Publication of papers 7 days before meeting	Covid slides prearranged to follow as per usual arrangement.	Covid Update
01.03.22	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Delay in publication of one agenda item by three days due to further advice on contents of report.	External Serious Incident Reviews
16.03.22	Health Board	Publication of papers 7 days before meeting	3 follow on paper (was published 1 day late) & 3 additional appendicies were published 2 working days late. Welsh Papers delayed upload due to translation	Operating Model, People & OD Strategy, Covid Briefing & Vascular Update
29.4.22	Partnerships People Population Health Committee	Publication of papers 7 days before meeting	2 follow on papers	Corporate Risk Register (Nick Lyons) Patient Story AMH (Matt Joyes)
26.05.22	Health Board	Publication of papers 7 days before meeting	Welsh Papers delayed upload due to translation & technical delays	All

Philippa Peake-Jones

Head of Corporate Affairs

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 13/06/22**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of Business Considered in Private Session to be Reported in Public
Cyfarwyddwr Cyfrifol: Responsible Director:	Interim Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Interim Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Audit Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

The Equality/SED duty is not applicable. This report is administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups and the report does not relate to a decision, strategic or otherwise).

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Orders require 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.

The issues listed below were considered by the Audit Committee at the private Committee meeting of 15/03/21:

- Minutes of the Private Session of Audit Committee held on 14/12/21 and Summary Action Log
- Register of Chair's Actions
- Post Payment Verification Progress Report
- Financial Conformance Report
- Schedule of Financial Claims
- Counter Fraud Progress Report, including Dental Assurance Report update pending confirmation of new performance metrics.
- Update on Internal/External Audit Actions (Tracker Tool).

Asesiad / Assessment & Analysis

Strategy Implications

This report is purely administrative. There are no associated strategic implications other than those that may be included in the individual reports.

Financial Implications

This report is purely administrative. There are no associated financial implications other than those that may be included in the individual reports.

Risk Analysis

This report is purely administrative. There are no associated risk implications other than those that may be included in the individual reports.

Legal and Compliance

Compliance with Standing Orders

Impact Assessment

This report is purely administrative. There are no associated impacts or specific assessments required.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee - 30th June 2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	External Audit – Audit Wales Reports
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary, on behalf of the Executive Team
Awdur yr Adroddiad Report Author:	Andrew Doughton
Craffu blaenorol: Prior Scrutiny:	All final Wales Audit Office reports on Betsi Cadwaladr University Health have passed through a clearance process with the lead Executive Director.
Atodiadau Appendices:	• Appendix 1 - Audit Wales programme update • Appendix 2 – Audit Plan •

Argymhelliad / Recommendation:

The Audit Committee is requested to:
- Receive and discuss the programme update.
- Approve the Annual Plan

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The documents include the regular audit update alongside the 2022 Audit Plan

Cefndir / Background:

The update provides an overview of progress of the external audit programme

Asesiad / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Opsiynau a ystyriwyd / Options considered

Goblygiadau Ariannol / Financial Implications The update provides an overview of progress of the external audit programme
Dadansoddiad Risk / Risk Analysis
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Asesiad Effaith / Impact Assessment .

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: June 2022

Document reference: 2996A2022

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value for money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2022.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of Health Board's 2021-22 financial statements.	Certification and submission of the Health Board's 2021-22 draft financial statements to Welsh Government is delayed. The audit remains ongoing as we work though issues with the Health Board's finance team. The opinion will be issued once our audit is work concluded.
Audit of the 2021-22 Funds Held on Trust Accounts	The audit will take place during November 2022 and December 2022. Our audit report will be issued in December 2022.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans.

Exhibit 2 – Work completed

Area of work	Audit Committee
Audit Plan	June 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead Gill Harris	This review is examining the progress made in response to our 2015 recommendations. The report will also take stock of the significant elective backlog challenges within this specialty.	Drafting report
Review of Unscheduled Care Executive Lead Gill Harris	Our Unscheduled Care data tool and blog was published in April 2022. The remainder of the review will be split into three areas: Part 1: Patient Flow out of Hospital Part 2: Access to the Unscheduled Care System Part 3: National arrangements for supporting the unscheduled care system	Data tool and blog published in April 2022 Fieldwork for part 1 planned for summer 2022 Work on parts 2 and 3 will being in autumn 2022

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Follow-up outpatients Executive Lead Gill Harris	This work will provide a high-level commentary on the overall position of the Health Board, effectiveness of adoption of new technologies and ways of working, and to consider plans for recovering follow up outpatient performance. This work will also examine progress against any outstanding recommendations from our previous review of Follow up outpatients.	Fieldwork delayed from March to June 2022 to reflect Health Board's ability to support the audit
NHS Structured Assessment 2022 Executive Lead Jo Whitehead	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning Use of resources (such as digital resources, estates, and other physical assets).	Fieldwork planned for summer 2022

Exhibit 4 – Planned work not yet started

Topic	Focus of the work	Current status
Use of additional Welsh Government strategic assistance funding	This work will follow on from our high-level review last year to consider the use of the additional Welsh Government funding allocation, where possible whether the funding is enabling intended improvements, and future plans.	Not yet started

Topic	Focus of the work	Current status
Workforce risks	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs	Fieldwork due to begin Autumn 2022

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 There have been no Good Practice Exchange (GPX) events since we last reported to the Committee in March 2022. Details of future events are available on the GPX website.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts and Public Administration Committee to support its scrutiny of public expenditure.

8 **Exhibit 5** provides information on the NHS-related or relevant national studies published in the last 12 months.

Exhibit 5 – Recent NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Tackling the Planned Care Backlog in Wales	May 2022
Unscheduled Care in Wales: Data Tool and Blog	April 2022
Direct Payments for Adult Social Care	April 2022
Joint working between Emergency Services	January 2022
Care Home Commissioning for Older People	December 2021
Picture of Healthcare	October 2021
Taking care of the carers	October 2021
Rollout of the Covid-19 vaccination programme in Wales	June 2021

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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.

Archwilio Cymru
Audit Wales

2022 Audit Plan – Betsi Cadwaladr University Health Board

Audit year: 2022-23

Date issued: April 2022

Document reference: 2869A2022

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

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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.

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

Contents

2022 Audit Plan

About this document

1 This document sets out the work I plan to undertake during 2022 to discharge my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

Impact of COVID-19

2 The COVID-19 pandemic has had an unprecedented impact on the United Kingdom and the work of public sector organisations.

3 While Wales is currently at Coronavirus Alert Level 0, Audit Wales will continue to monitor the position and will discuss the implications of any changes in the position with your officers.

Audit of financial statements

4 I am required to issue a report on the Health Board's financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure. I lay them before the Senedd together with any report that I make on them. In preparing such a report, I will:

- give an opinion on your financial statements;
- give an opinion on the proper preparation of key elements of your Remuneration and Staff Report; and
- assess whether other information presented with the financial statements are prepared in line with guidance and consistent with the financial statements.

5 I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities, along with further information about our work.

6 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 misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to the Audit Committee prior to completion of the audit.

7 Any misstatements below a trivial level (set at 5% of materiality) I judge as not requiring consideration by those charged with governance and therefore will not report them.

8 There have been no limitations imposed on me in planning the scope of this audit.

Audit of financial statement risks

9 The following table sets out the significant risks that have been identified for the audit of your financial statements.

Exhibit 1: audit of financial statement risks

Financial audit risks	Proposed audit response
Significant risks	
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 240.31-33].	My audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.26-27].	My audit team will consider the completeness of miscellaneous income.
There is a risk of material misstatement due to fraud in expenditure and as such is treated as a significant risk [PN 10].	My audit team will: • substantively test all material areas of pay and non-pay expenditure; • review the basis of accruals for any estimation biases; • review the year-end cut-off of expenditure; and • review the basis of new provisions and increases in provision levels in year.

Financial audit risks	Proposed audit response
Although the Health Board is currently forecasting to break even in 2021-22, it will once again fail to meet its first financial duty to break even over a three-year period. Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. The financial pressures increase the risk that management judgements and estimates could be biased to achieve the financial duty.	My audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.
Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.
The implementation of the ‘scheme pays’ initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of Matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.

Financial audit risks	Proposed audit response
Other areas of audit attention	
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include accounting for decommissioning field hospital and their associated costs; fraud, error and regularity risks of additional spend; valuation (including obsolescence) of year-end inventory including PPE; and estimation of annual leave balances.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.
Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.
Disclosure of related party transactions are important as these transactions identify relationships that might materially prevent a body pursuing its separate interests or allow the body to prevent another party from pursuing its interests independently. We have identified related party transactions as material to the accounts as they can provide scope to distort financial information and/or obscure the substance of transactions. We have previously identified weaknesses in the Health Board's systems for identifying and recording	My audit team will: • review whether all required Declarations of Interest have been completed; and • review the content of all declarations and ensure that information has been correctly recorded within the Health Board's systems and the financial statements.

Financial audit risks	Proposed audit response
declarations of interest for those related parties that are required to be included within the financial statements and reported this to you within our Audit of the Accounts report 2020-21.	
The Remuneration Report contains important disclosures required by Welsh Government and accounting standards. Our review of the disclosures within the 2020-21 Remuneration Report identified issues with the completeness and accuracy of the information reported. Discussions with the Health Board confirmed this was due to the officer responsible for the preparation of the report not having complete information relating to senior officer pay. We previously recommended that the Health Board needs to ensure that the officer responsible for the preparing the Remuneration Report is appropriately positioned to understand the disclosure requirements, has complete access to all the relevant information for its preparation, is able to provide the necessary audit evidence and can directly address any audit queries arising.	My audit team will undertake some early work to understand the processes for collating information to support the Remuneration Report and will highlight any concerns with senior management.

10 In addition to my responsibilities in respect of the audit of the body's statutory financial statements set out above, I am also required to certify a return to the Welsh Government which provides information about Betsi Cadwaladr University Local Health Board to support preparation of Whole of Government Accounts.

Performance audit work

11 In addition to my Audit of Financial Statements, I must also satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

12 My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

13 During 2020-21 I consulted public bodies and other stakeholders on how I will approach my duties in respect of the Well-being of Future Generations (Wales) Act 2015 for the period 2020-2025. In March 2021, I wrote to the 44 public bodies designated under the Act setting out my intentions, which include:

- carrying our specific examinations of how public bodies have set their well-being objectives, and
- integrating my sustainable development principle examinations within my local audit programme.

14 My auditors are liaising with the Health Board to agree the most appropriate time to examine the setting of well-being objectives.

15 **Exhibit 2** sets out my current plans for performance audit work in 2022.

Exhibit 2: My planned 2022 performance audit work at the Health Board

Theme	Approach/key areas of focus
NHS Structured Assessment	Structured assessment will continue to form the basis of the work auditors do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2022 structured assessment work will review the corporate arrangements in place at the Health Board in relation to: • Governance and leadership; • Financial management; • Strategic planning; and • Use of resources (such as digital resources, estates, and other physical assets).
All-Wales Thematic work	As part of my 2022 plan, I intend to undertake an assessment of the workforce risks that NHS bodies are experiencing currently and are likely to experience in the

Theme	Approach/key areas of focus
	future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs. I will tailor this work to align to the responsibilities of individual NHS bodies in respect of workforce planning. I also plan to use an element of the 2022 audit fee to respond to aspects of service delivery where my insight and knowledge across Wales will provide value to NHS bodies. The exact focus of this work will be confirmed following a broader consultation on my overall programme of audit work for Audit Wales for 2022-23 and beyond (see paragraphs 18 and 19).
Locally focused work	**Use of additional Welsh Government strategic assistance funding** Last year I performed a high-level assessment of the plans for spending the additional Welsh Government funding allocation. As part of this year's plan, I will consider the how the Health Board is using its funding and where possible, identify whether the funding is enabling intended improvements. My team will also continue to monitor the risks facing the Health Board and will consider whether additional local review is required. Any changes to the plan would be agreed with executive officers and shared with the Audit Committee.
Implementing previous audit recommendations	My structured assessment work will include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

16 In March 2022, I published a consultation inviting views to inform our future audit work programme for 2022-23 and beyond. In particular, it considers topics that may be taken forward through my national value for money examinations and studies and/or through local audit work across multiple NHS, central government, and local

government bodies. As we develop and deliver our future work programme, we will be putting into practice key themes in our new five-year strategy, namely:

- the delivery of a strategic, dynamic, and high-quality audit programme; supported by
- a targeted and impactful approach to communicating and influencing.

17 The possible areas of focus for future audit work that we set out in the consultation were framed in the context of three key themes from our Picture of Public Services analysis in autumn 2021, namely: a changing world; the ongoing pandemic; and transforming service delivery. We also invited views on possible areas for follow-up work.

18 We will provide updates on the performance audit programme though our regular updates to the Audit Committee.

Fee, audit team and timetable

19 My fees and the planned timescales for completion of the audit are based on the following assumptions:

- the financial statements are provided to the agreed timescales, to the quality expected and have been subject to quality assurance review;
- information provided to support the financial statements is in accordance with the agreed audit deliverables document[1];
- appropriate facilities and access to documents are provided to enable my team to deliver our audit in an efficient manner;
- all appropriate officials will be available during the audit;
- you have all the necessary controls and checks in place to enable the Accounting Officer to provide all the assurances that I require in the Letter of Representation addressed to me; and
- Internal Audit's planned programme of work is complete, and management has responded to issues that may have affected the financial statements.

Fee

20 As set out in our Fee Scheme 2022-23 our fee rates for 2022-23 have increased by 3.7% as a result of the need to continually invest in audit quality and in response to increasing cost pressures.

21 The estimated fee for 2022 is set out in **Exhibit 3**. This represents a 3.7% increase compared to your actual 2021 fee.

[1] The agreed audit deliverables documents set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.

Exhibit 3: audit fee

Audit area	Proposed fee for 2022 (£)[2]	Actual fee for 2021 (£)
Audit of Financial Statements	222,723	214,820
Charitable Funds	20,937	20,180
Performance audit work:		
• Structured Assessment	51,549	63,563
• All-Wales thematic review[3]	71,261	72,702
• Local projects	56,530	36,656
Performance work total	179,340	172,921
Total fee	423,000	407,921

22 Planning will be ongoing, and changes to our programme of audit work and therefore the fee, may be required if any key new risks emerge. We shall make no changes without first discussing them with the Director of Finance.

23 Further information on my fee scales and fee setting can be found on our website.

Audit team

24 The main members of the audit team, together with their contact details, are summarised in **Exhibit 4**.

Exhibit 4: my local audit team

Name	Role	Contact number	E-mail address
Dave Thomas	Engagement Director (Performance Audit)	02920 320604	Dave.Thomas@audit.wales
Matthew Edwards	Audit Director (Financial Audit)	02920 320663	Matthew.Edwards@audit.wales

[2] The fees shown in this document are exclusive of VAT, which is not charged to you.

[3] As detailed in the respective audit plans.

Name	Role	Contact number	E-mail address
Michelle Phoenix	Audit Manager (Financial Audit)	07966 073281	Michelle.Phoenix@audit.wales
Andrew Doughton	Audit Manager (Performance Audit)	07812 094642	Andrew.Doughton@audit.wales
Simon Monkhouse	Audit Lead (Financial Audit)	02920 829394	Simon.Monkhouse@audit.wales
Fflur Jones	Audit Lead (Performance Audit)	07773 193627	Fflur.Jones@audit.wales

25 We can confirm that team members are all independent of you and your officers.

Timetable

26 The key milestones for the work set out in this plan are shown in **Exhibit 5**. As highlighted earlier, there may be a need to revise the timetable in light of developments with COVID-19.

Exhibit 5: Audit timetable

Planned output	Work undertaken	Report finalised
2022 Audit Plan	December 2021 to March 2022	April 2022
Audit of Financial Statements work: • Audit of Financial Statements Report • Opinion on Financial Statements	January to June 2022	June 2022

Planned output	Work undertaken	Report finalised
Performance audit work: • Structured Assessment • All-Wales thematic work • Local project work	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

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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.

Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee 30th June 2022**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Internal Audit Progress Report - 1st March to 31st May 2022** **Head of Internal Audit Opinion & Annual Report 2021/2022**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Molly Marcu – Interim Board Secretary
Awdur yr Adroddiad **Report Author:**	Dave Harries – Head of Internal Audit Nicola Jones – Deputy Head of Internal Audit
Craffu blaenorol: **Prior Scrutiny:**	The progress report and Head of Internal Audit opinion and annual report has been considered and approved by the Interim Board Secretary.
Atodiadau **Appendices:**	• Appendix 1: Progress Report • Appendix 2: Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists • Appendix 3: Clinical Audit • Appendix 4: Nursing Roster Management – Introduction of E-timesheets for Agency staff • Appendix 5: On-Call arrangements • Appendix 6: Business Continuity Plans • Appendix 7: Head of Internal Audit opinion and annual report for 2021/22

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report.
- Approve the change to issuing draft reports and remove issuing discussion draft reports.
- Note and receive the Head of Internal Audit opinion and annual report for 2021/22.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**	√	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

The progress report is produced in accordance with the requirements as set out within

the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.

The annual report and opinion is produced In accordance with the Public Sector Internal Audit Standards: Standard 2450 – Overall Opinions.

Cefndir / Background:

The progress report summarises fifteen assurance reviews finalised since the last Committee meeting in March 2022, with the recorded assurance as follows:

- Substantial assurance (green) – one;
- Reasonable assurance (yellow) – eight;
- Limited assurance (amber) – five; and
- Assurance not applicable (grey) – two.

The report also details:

- Reviews issued at draft reporting stage, work in progress and recommendations subject to follow-up in the period.

In accordance with the Public Sector Internal Audit Standards, the head of internal audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the Health Board's risk management, control and governance processes (i.e. the system of internal control).

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2021/22 was approved by the Audit Committee in March 2021, with changes considered and approved by the Committee throughout the year.

Financial Implications

The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.

Risk Analysis

The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.

The annual report and opinion for 2021/22 reports the outcome of all risk-based reviews completed in the financial year.

Legal and Compliance

The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.5 Reviewing internal audit assignment reports.*

The Head of Internal Audit Opinion and Annual Report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.6 Reviewing the Head of Internal Audit's annual opinion.*

Impact Assessment

The Internal Audit report provides third line independent assurance to the Board,

through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

This report does not, in our opinion, have an impact on equality nor human rights beyond what is drawn out specifically in respect of individual audits and is not discriminatory under equality or anti-discrimination legislation.

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1st March 2022 to 31st May 2022

NWSSP Audit and Assurance Services

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

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

Contents

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Introduction

1. 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 2021/22 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Office of the Board Secretary.

Reports Issued

2. Several reviews have been finalised in conjunction with Health Board management. A summary of these reviews is provided below in Table 1.

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
HASCAS/ Ockenden (Workforce) Review completed February 2022 with Executive approval March 2022	N/A	-	-	-	We reviewed the evidence for the closure of each specific HASCAS / Ockenden recommendation highlighted in the Assurance objective for Workforce. We identified that all five Workforce recommendations were partially implemented. Whilst there is evidence of actions taking place, there is not sufficient evidence to demonstrate the actions have been fully implemented.
Decommission of Ysbyty Enfys Temporary Hospitals Review completed February 2022 with Executive approval March 2022	N/A	-	-	-	The review was limited to the decommission contract costs, as advised by the Director of Finance following confirmation from KPMG, and ensuring the report presented to the Executive Team on the 11th November 2020 detailing the 'Proposed Ysbyty Enfys Decommissioning Programme' was adhered to. We have noted considerations for the future, these being: • Clear communication required between Executive Team and Project Team. • Ensure projects have a clear Strategy / Plan to safeguard objectives are being met.

Title	Assurance Level	High	Medium	Low	Key Messages
					• Ensure robust governance arrangements in place at the outset. • Ensure reporting lines and requirements are clear from the project onset. • Ratified documentation of the project team meetings to evidence discussions / decisions and issues.
Capital Funded Systems Review completed April 2022 with Executive approval April 2022	Substantial	-	1	-	The review assessed the risk-based approach and scrutiny applied to the allocation of discretionary funds, and how slippage or new funding is managed. ensuring divisions / core programmes comply with the requirement to rank submissions. Our only finding related to ensuring divisions / core programmes comply with the requirement to rank submissions.
Employment of medical locum doctors Review completed February 2022 with Executive approval March 2022	Reasonable	1	1	-	The review sought to ensure that the Health Board Standard Operating Procedure "The Medical and Dental Staff Bank Principles" is adhered to, and a robust process in place for ensuring pre-employment checks are undertaken, including references. We identified that all requests had been appropriately approved and authorised, however justification notes to show reason for the request or any additional useful information were unavailable for some requests and do not provide useful information for others. We could not establish formal process in place to monitor contract performance with the contractor. We were unable to determine how information received from the service provider is being utilised to monitor performance or alternatively bring costs down.

Title	Assurance Level	High	Medium	Low	Key Messages
Cluster working - Governance Review completed February 2022 with Executive approval March 2022	Reasonable	-	1	2	The purpose of this review was to establish the robustness of governance arrangements in place for a sample of Primary Care Clusters. We identified good practice at: • Conwy West who maintain Cluster specific risk register. • Wrexham South sought to engage with the public to inform their IMTP. • East Area Cluster Leads meeting maintain and review an action log of agreed actions. However, we noted the following that require focus: • Terms of Reference need reviewing and updating. • Meeting actions are not tracked and updated. • Inconsistent approach to risk management.
Financial Management, Reporting and Budgetary Control Review completed March 2022 with Executive approval April 2022	Reasonable	-	1	1	The review sought to ensure that budgetary control and financial reporting processes are operating effectively. The review identified the need to ensure segregation of duties when completing virements and their timely completion coupled with reflecting on findings from the audit questionnaire as completed by Budget Holders, for which some issues were highlighted.
Network and Information Systems Regulations 2018 (NIS Regulations Review completed	Reasonable	-	2	1	We reviewed arrangements in place for the implementation of the NIS Directive in the Health Board. We have noted that the funding implications for the improvement action plan have not yet been fully defined and require focus by the Health Board.

Title	Assurance Level	High	Medium	Low	Key Messages
March 2022 with Executive approval April 2022					
Voluntary Early Release Scheme Review completed April 2022 with Executive approval May 2022	Reasonable	1	-	-	The Health Board updated its Voluntary Early Release Scheme (VERS) in November 2021 and issued it to officers on 16th November 2021 under the subject heading of *Operating Model – Options Engagement Document – VERS*. The Health Board enhanced some elements of the Model Scheme which had a positive impact on the expected control and was overall well controlled, particularly by Workforce & OD. However, the narrative provided to support individual applications have been scant and did not, in our view, provide adequate detail to capture and mitigate the risks from the loss of such senior staff during a period of substantial change and operational challenge for the Health Board - There was a lack of evidence and detail to ensure compliance with *Section 7: VERS Approval Process* of the Scheme.
Impact Assessments Review completed April 2022 with Executive approval May 2022	Reasonable	1	1	-	The purpose of this review was to establish the robustness of controls in place for the completion and scrutiny of Impact Assessments for a sample of Health Board developments / strategies / policies or schemes. The review identified the Health Board needs to ensure the requirements of all Impact Assessments are clearly defined, currently this is not the case. Our review of a sample of papers presented to Board/Committee identified that Impact Assessments have not been undertaken or were incomplete.

Title	Assurance Level	High	Medium	Low	Key Messages
Risk Management Review completed April 2022 with Executive approval June 2022	Reasonable	1	6	1	The review was to ascertain how effectively the risk management strategy and policy is embedded in the Health Board. The audit focused on policies, local risk registers, risk escalation/de-escalation, moving from 5 tiers to 3 tiers, and staff training. Our review identified the following: • The number of clinical risks on divisional risk registers does not appear to be consistent with the level of risk facing the Health Board. • A review of directorate risk registers highlighted a number of fields that were not complete and risks labelled as the wrong tier. • Research & Development / North Wales Medical and Health Sciences School risks are not being managed in line with the Health Board Strategy / Policy. • We are unable to confirm that risks are escalated or de-escalated in a timely manner. • 'Never Events' are risks that should not occur – there has been an increase in 2021/22 but the live risk is managed at Tier 2, and should be reviewed. • Management have reconciled and accounted for all risks moving from 5 Tiers to 3 Tiers, however further work is required to provide assurance on the data following these changes.
Waste Management Review completed April 2022 with Executive approval June	Reasonable	-	2	-	We assessed the Health Board's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Title	Assurance Level	High	Medium	Low	Key Messages
2022					The matters requiring management attention following the review include: • The waste management policy had been partially communicated to key staff and effective communication will occur upon full implementation of mandatory training on ESR. • Non-compliance with the Covid-19 waste management standard operating procedure (NWSSP) that sets out approach for all healthcare settings. It is noted that waste management has returned to business as usual in some areas, and compliance has been affected by a number of outbreaks requiring all waste to disposed as clinical waste.
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists Review completed January 2022 with Executive approval March 2022	Limited	2	1	-	We assessed the Welsh Government initiated tranche 'patient' validation exercise and more broadly, the prioritisation of waiting lists for planned care and removal of patients from the waiting lists. Our review identified the following significant matters which require management attention: • The outpatient's governance spreadsheet requires tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. • Evidence from the risk stratification waiting list shows that patients within Orthopaedics and Urology as being overdue within the "Risk Strat/Reprioritised Status" section - This could result in patient harm if they are not seen within the original timescale noted when first risk stratified.

Title	Assurance Level	High	Medium	Low	Key Messages
Clinical Audit Review completed March 2022 with Executive approval April 2022	Limited	4	1	-	The review considered the adequacy of the systems and controls in place for the planning and completion of clinical audits. The significant matters which require management attention include: • Policy/Procedure document requires a review and a governance structure needs to be entered under appendix 1. • There is no evidence that the appropriate information has been reviewed to ensure the Clinical Audit Plan is risk focused i.e. incidents, complaints, never events. There is no formal risk assessment to support the rationale for Tier 2 audits. • Quarterly reports reflecting progress against the Clinical Audit Plan have not been regularly received at the overarching Clinical Effectiveness Group (CEG) or Quality, Safety and Experience Committee as a result of meetings being stood down due to COVID. • Timelines for completion and returns of Welsh Government National clinical audit proformas A and B are generally poor and not being met, including the non-completion and submission of forms.
Nursing Roster Management – Introduction of E-timesheets for Agency staff Review completed April 2022 with Executive approval May	Limited	3	1	-	The review considered the implementation and effectiveness of the new arrangements for Agency e-timesheets. The significant matters which require management attention include: • The majority of agency staff timesheets are not being submitted by agencies within 48 hours, as required in order to allow time to be reviewed for accuracy prior to payment.

Title	Assurance Level	High	Medium	Low	Key Messages
2022					• Shifts of over 12 hours require a one-hour break. Where a shorter break is entered by an agency this should be amended to one hour. This has not been applied within the Health Roster Bank Staff system to a number of shifts of 12 hours or more, which is resulting in incorrect pay/overpayments to agencies and increased costs to the Health Board. • Regular reports detailing shift changes are required to be sent to Heads of Nursing for monitoring on weekly basis. These are not being sent regularly and are providing all shift details, not just changes, resulting in shift changes not being reviewed.
On-call arrangements Review completed April 2022 with Executive approval May 2022	Limited	4	-	-	We reviewed on-call arrangements to ensure they were effective, have processes in place to ensure staff receive the relevant payments and compensatory rest periods. Our review of arrangements identified: • On-call arrangements have not been reviewed for a number of years. Several staff have raised the issue of on-call arrangements being unsafe, impacting patients, and have been awaiting the outcome of promised reviews. • The ratio and skill mix for rotas is not documented and there appears to be inequity as to who is included on some rotas. • Guidance on compensatory rest is included in Health Board policies, however these are all overdue for review. Half of staff who responded to our questionnaire were unaware of the guidance and the majority do not have the capacity to take compensatory rest.

Title	Assurance Level	High	Medium	Low	Key Messages
					• There is little training/guidance in place for those on call to familiarise themselves/refer to concerning responsibilities whilst on call/crib sheets for sites/services that they are unfamiliar with.
Business Continuity Plans Review completed May 2022 with Executive approval June 2022	Limited	2	1	-	The review assessed the status of Business Continuity Plans across the Health Board and considered the effectiveness in line with Health Board policies and procedures. Our review identified: • The Business Continuity Group have only met three times in two years. Attendance to the Working Group means that only one of the meetings in the last two years were quorate. • Of the expected 122 Business Continuity Plans for areas across the business, only 38% (47) have been finalised. • There is a lack of local engagement across the Health Board. This encompasses development of local plans, engagement in training, regular review and testing of plans already in place. • A formal escalation route with Executive ownership has recently been put in place, however we have not seen this in operation.

Work in Progress Summary

3. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
No 2022/23 draft reports issued.		

Fieldwork

4. The following 2022/23 reviews are currently in progress:
   - Charitable Funds – brief agreed and the review has commenced.
   - Voluntary Early Release Scheme (second round) – brief agreed and the review has commenced.
   - Comisiynydd y Gymraeg / Welsh Language Commissioner: Dogfennau ar y Wefan / Documents on the Website – brief agreed and the review has commenced.
   - Effective Governance arrangements Ysbyty Gwynedd – brief agreed and the review has commenced.
   - Effective Governance arrangements Ysbyty Wrexham Maelor – brief agreed and the review has commenced.
   - Management of utility usage, expenditure and efficiency – brief agreed and the review has commenced.
   - Speak Out Safely – brief issued, awaiting Executive approval.
   - Board and Committee Reporting (adequacy and quality of papers) – brief issued, awaiting Executive approval following amendments made.
   - Chair's Action – brief issued, awaiting Executive approval following amendments made.
   - Welsh Information Governance Toolkit – brief agreed and the review has commenced.
   - Digital Strategy – brief agreed – to commence in Q2.

Follow Up

5. Follow up reviews remain in progress as and when actions are noted as 'Implemented – Final Client Approved' for limited and no assurance internal audit reviews only. The follow-up is based solely upon the evidence and narrative included within TeamCentral which supports final approval by the relevant executive lead.

6. Table 3 details the follow-up review(s) of individual recommendations undertaken in the period and whether they have been implemented (Closed – Verified) or rejected (with supporting narrative).

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Budgetary Control and Financial Reporting 2020-21	Clear Scheme of Delegation	Closed – verified
Budgetary Control and Financial Reporting 2020-21	Reports addressed	Closed – verified
Budgetary Control and Financial Reporting 2020-21	Accountability Agreements	Closed – verified
Budgetary Control and Financial Reporting 2020-21	Questionnaire	Closed – verified
Engagement of Interim Appointments 2020-21	Interim appointments governance – revised standard operating procedure	Closed – verified
Engagement of Interim Appointments 2020-21	Interim appointments governance - Reporting	Closed – verified
Upholding Professional Standards in Wales 2021-22	UPSW reporting to Board / Committee	Closed – verified
Upholding Professional Standards in Wales 2021-22	Scheme of Reservation and Delegation	Closed – verified
Statutory Compliance – Asbestos Management	Training	Closed - verified

Contingency/Organisational Support/Advice

7. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems, and processes, with increased time being used to support attendance and provide input at the three project meetings we are in attendance.

8. During the period, the following review/advice/guidance/support has been provided:

   - Attendance at the Health Board Symphony/National WEDS Project Board.
   - Attendance at the Quality Strategy Peer Review Panel.

Delivering the Plan

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

10. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high-level risks.

11. As we are at the start of the plan delivery, there are no amendments to the plan at this stage.

12. 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) with the assurance provided.

13. Table 3 is reporting a positive status across all three indicators. The management response to draft reports has increased from 43% to 70% - we are grateful for the support of the Executive Team in achieving this turnaround in the indicator and is based on all thirty final reports issued for 2021/22.

    Following a meeting with the Chief Executive and Interim Board Secretary we have, subject to Audit Committee approval, agreed a revised process concerning the issue of discussion/draft reports. We will no longer issue a discussion draft report, and, keeping in line with the 20-working day indicator, we will now issue the formal draft report to management and Executive Director for a total of 20 working days for management response and Executive approval, requesting comments on factual accuracy within 5 working days. This ensures the Executive Director is sighted on the report within the whole 20 working days.

Table 3 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Green	70%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 4 – Core Plan 2021-22

Planned output	Outline timing	Status	Assurance
Risk Management	Q4	Final report issued	Reasonable
Governance structure	Q4	Deferred.	-
Targeted Intervention	Q3	Final report issued.	Reasonable
Transformation of services	Q3/Q4	Deferred.	-
Impact Assessments	Q3	Final report issued	Reasonable
Standards of Business Conduct: Declarations	Q2	Final report issued.	Limited

Planned output	Outline timing	Status	Assurance
Integrated Service Boards (ISB)	Q2/Q3	Final report issued.	Limited
Budgetary Control & Financial Reporting, including COVID-19 financial governance	Q4	Final report issued.	Reasonable
Procurement: Contract Management & Single Tender Waivers	Q1	Final report issued.	Reasonable
Value Based Healthcare	Q3	Deferred.	-
Learning Lessons	Q1/Q2	Final report issued.	Reasonable
HASCAS & Ockenden external reports – Recommendation progress and reporting (Recs 14 & 15)	Q1/Q4	Final briefing paper issued.	Assurance Not Applicable
HASCAS & Ockenden – Workforce	Q4	Final briefing paper issued	Assurance Not Applicable
Clinical Audit	Q2/Q3	Final report issued.	Limited
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	Q1	Final report issued.	Limited
Network and Information Systems Regulations 2018 (NIS Regulations)	Q4	Final report issued	Reasonable
Digital Strategy	Q3	Deferred.	-
Cluster working - Governance	Q2/Q3	Final report issued.	Reasonable
Unscheduled Care	Q3	Deferred.	-
Business Continuity Plans	Q2/Q3	Final report issued.	Limited
Secondary Care Division – Ysbyty Glan Clwyd	Q2	Final report issued.	Assurance Not Applicable
Maternity Cross-Border Arrangements	Q1/Q2	Final report issued.	Reasonable
Recruitment – Employment of medical locum doctors	Q3	Final report issued.	Reasonable
Roster management	Q4	Final report issued.	Limited
Establishment Control – Leaver Management	Q1/Q2	Final report issued.	Limited
Upholding Professional Standards in Wales	Q1	Final report issued.	Reasonable
On-Call arrangements	Q3	Final report issued.	Limited
Statutory Compliance: Asbestos Management	Q1	Final report issued.	Reasonable

Planned output	Outline timing	Status	Assurance
Waste Management	Q3	Final report issued.	Reasonable
Preparedness for Climate Change/ Decarbonisation	Q4	Deferred.	-
Capital Funded Systems	Q4	Final report issued.	Substantial
Integrated Audit and Assurance Plans	TBC	Deferred due to no major capital scheme progressing.	-
Carry over: Temporary Hospitals – Follow-up of KPMG recommendations	Q1/Q4	Final report issued.	Assurance Not Applicable
Carry over: Follow up of previous Healthcare Inspectorate Wales reports	Q1	Final report issued.	Assurance Not Applicable
Contingency: Security Invoice Review	Q1	Final report issued.	Assurance Not Applicable
Contingency: Decommission of Ysbyty Enfys temporary hospitals	Q3	Final report issued.	Assurance Not Applicable
Voluntary Early Release Scheme	Q4	Final report issued.	Reasonable

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	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.

Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists
Final Internal Audit Report

March 2022

Betsi Cadwaladr University Health Board

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

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

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Review reference:	BCU-2122-14
Report status:	Final Internal Audit Report
Fieldwork commencement:	7 October 2021
Fieldwork completion:	6 January 2022
Debrief meeting / Discussion draft:	6 January 2022
Draft report issued:	2 February 2022
Management response received:	11 March 2022
Approval and final report issued:	18 March 2022
Auditor(s):	Principal Auditor, Deputy Head of Internal Audit
Executive sign off:	Deputy Chief Executive / Interim Director of Regional Delivery
Distribution:	Head of Ambulatory Care, Directorate General Manager - Surgery, Anaesthetics & Critical Care, Directorate General Manager - (General Surgery West) Directorate General Manager (General Surgery Central)
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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.

Executive Summary

Purpose

The objective of the audit was to assess the Welsh Government initiated tranche 'patient' validation exercise and more broadly, the prioritisation of waiting lists for planned care and removal of patients from the waiting lists.

Overview

We have issued limited assurance on this area.

The significant matters which require management attention include:

- The outpatient's governance spreadsheet needed tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information.
- Evidence from the risk stratification waiting list (2.16) shows that patients within Orthopaedics and Urology as being overdue within the "Risk Strat/Reprioritised Status" section.
- 56 reasons for the removal of patients from waiting list. Information extracted from respective PAS systems for East, Central and West slightly differ in the wording of the reasons, making it difficult when merging reports as well as potential confusion for inputting.

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

	Assurance objectives	Assurance
1	Oversight and review of the status and progress of waiting lists within the Health Board	Reasonable
2	The Welsh Government (WG) initiated, locally delivered tranche 'patient' validation exercise	Limited
3	Assessment of clinical risks relating to delays, with these recorded and actioned where appropriate.	Limited
4	Patients removed from waiting lists.	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance objective	Control Design or Operation	Recommendation Priority
1	Future arrangements for large scale tranche validation exercises		Operation	High
2	Assessment of clinical risks relating to delays		Operation	High
3	Patients removed from waiting lists		Operation	Medium

1. Introduction

1.1 The review of Planned Care – Waiting List Management has been completed in line with the 2021/22 Internal Audit Plan. The review has sought to provide the Health Board with assurance that waiting lists are accurate and being managed appropriately, with risks to patients assessed and monitored.

Following the impact of the COVID-19 pandemic, the health board is intending to recover delayed planned care activity in a timely, risk-based manner. As of July 2021, there were more than 40,000 patients affected. Clinical and Operational teams are taking actions to address the backlog, with specialties managing waiting lists through validation of patient data and assessment of clinical risks.

1.2 The following risks are identified at the outset of the review:

- waiting lists are not effectively managed, resulting in inaccurate lists and delays to patients (this risk was considered only in the context of the tranche validation exercise);
- patients have been removed from lists without appropriate communication; and
- there is a lack of assurance that clinical risks have been assessed.

1.3 The internal audit has assessed the adequacy and effectiveness of the internal controls in operation. Weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

1.4 This audit has reviewed the implementation of the one-off Welsh Government initiated tranche patient validation (not the standard patient validation carried out within each site as part of their core functions) – it is not expected that this will be repeated in this way again. This report will support the lessons learnt currently being carried out on that one-off initiative which will inform how the Health Board moves towards automation/digitisation/business as usual.

1.5 The objective of the audit was to assess the arrangements in place for review and prioritisation of waiting lists for planned care. The review has considered the following areas:

- oversight and review of the status and progress of waiting lists within the Health Board;
- the WG initiated, locally delivered tranche 'patient' validation exercise;
- assessment of clinical risks relating to delays, with these recorded and actioned where appropriate; and
- patients removed from waiting lists, to ensure they have received the appropriate communication.

The audit has sampled Urology, Orthopaedics and Dermatology.

2. Detailed Audit Findings

Objective 1: Oversight and review of the status and progress of waiting lists

2.1 There is a Planned Care Transformation Group (PCTG) in place which meets fortnightly and has oversight of the waiting lists within the Health Board. The Terms of Reference (ToR) includes the following objective:

Treatment of patients

Monitoring of cohort 1 and 2 and the allocation of funding to differing services to reduce backlogs and scrutinise business cases from a planned care perspective.

2.2 We were provided with the minutes of four of the meetings and confirm that all were quorate, with appropriate attendance. Cohort 1 and 2 are an agenda item on three of the sets of minutes however discussion taking place on both cohorts is visible within all the minutes provided. The Group reports to the Executive team meeting and we were provided with evidence to demonstrate this reporting for the meetings in June and August 2021.

2.3 Previously, a Planned Care Performance Review Group met monthly, however these have since been superseded, moving to weekly with overarching access meetings alternating between Surgical and Women's and Area, Medical, Diagnostics and Therapies. This meeting reports into the Planned Care Transformation Group, the meetings are not minuted but an action log is in place.

2.4 Local access meetings take place weekly, chaired by the Directorate General Managers (Surgery) and the Interim Assistant Director of Community Services (Dermatology). Waiting lists are reviewed at a patient level to determine actions that need to be taken to ensure patients are treated as soon as possible. The information from these meetings is report into the overarching access meeting.

Conclusion

2.5 There are oversight and reporting arrangements in place within the Health Board that oversee the total waiting lists, and local meetings that review the lists at a patient level. The Executive Team are provided with an update from the Planned Care Transformation Group.

Objective 2: Welsh Government initiated, locally delivered tranche 'patient' validation exercise

2.6 'Stage of Pathway' is used to identify the point at which a patient is waiting in respect of their overall diagnosis and treatment. The definition of each stage is shown in the table below.

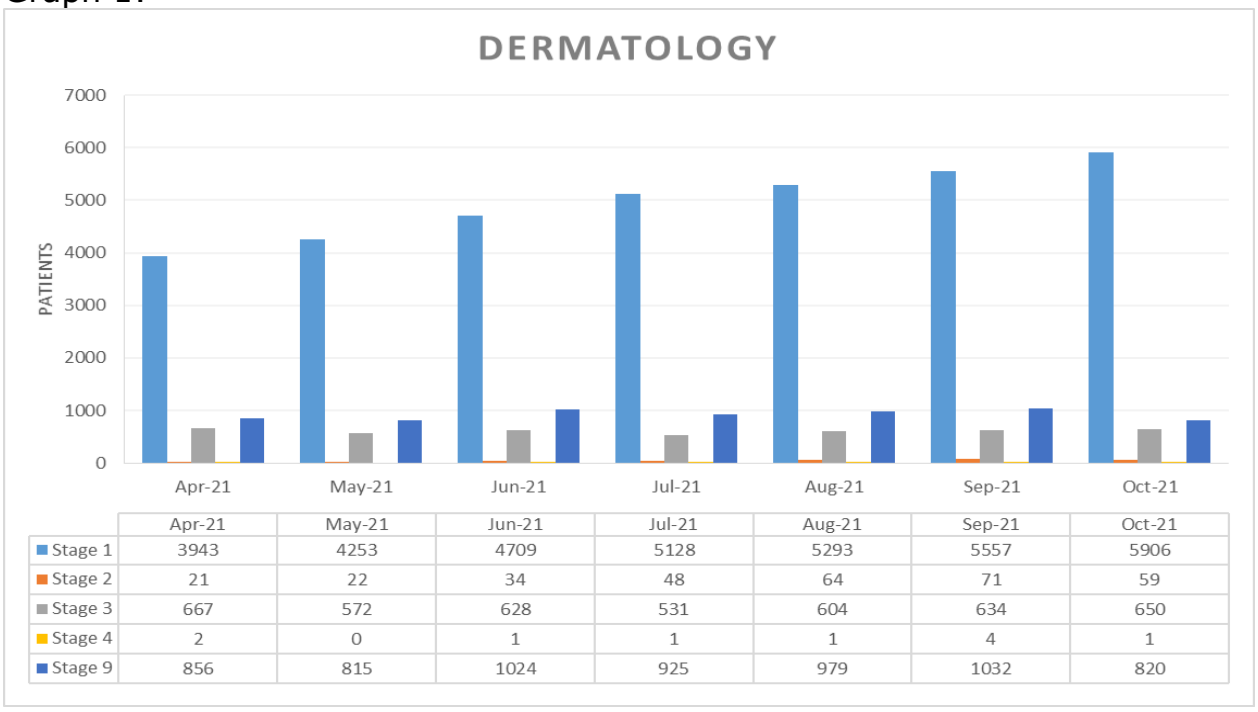
Table 1: NHS Wales Data Dictionary Stages of pathway

Stages of the Pathway	Stage of the Pathway
1	*Waiting for a new outpatient appointment. A new Outpatient Appointment may come from any referral source. A patient will be at Stage 1 only once.*
2	*Waiting for a diagnostic or Allied Health Professional (AHP) test, intervention or result. For relevant diagnostic and AHP services.*
3	*Waiting for a follow-up outpatient appointment or waiting for a decision following:* *1) An outpatient appointment.* *2) A diagnostic or AHP intervention result.* *3) Or where the patient is waiting, and the stage is uncertain/unknown.*
4	*Waiting for an admitted diagnostic or therapeutic intervention (i.e., treatment) only.*
9	*Not applicable – e.g., closed pathway*

2.7 We obtained data from Informatics for April 2021 – October 2021 displaying referral to treatment (RTT) summary details sent to the Digital Health and Care Wales (DHCW) monthly. The tables below depict what movement through the stages has taken place during the time period stated within the sampled areas of Dermatology, Urology and Orthopaedics.

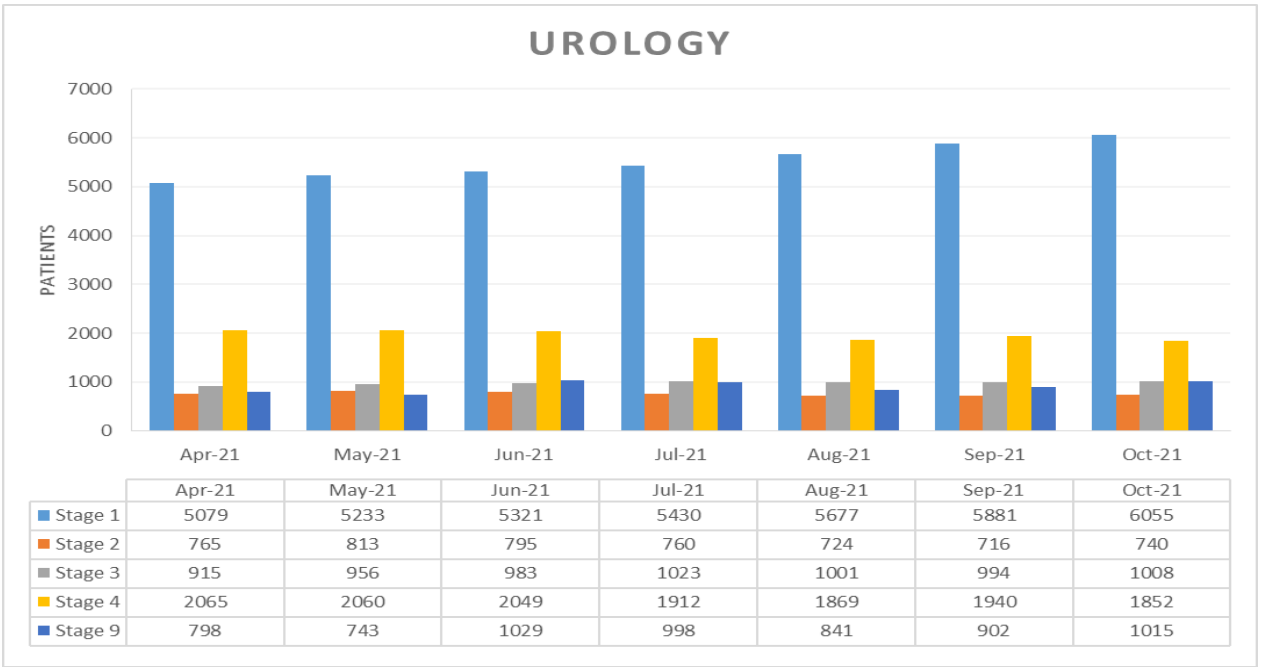
2.8 The data within the graphs shows little movement within the stages over the period stated.

Graph 1:



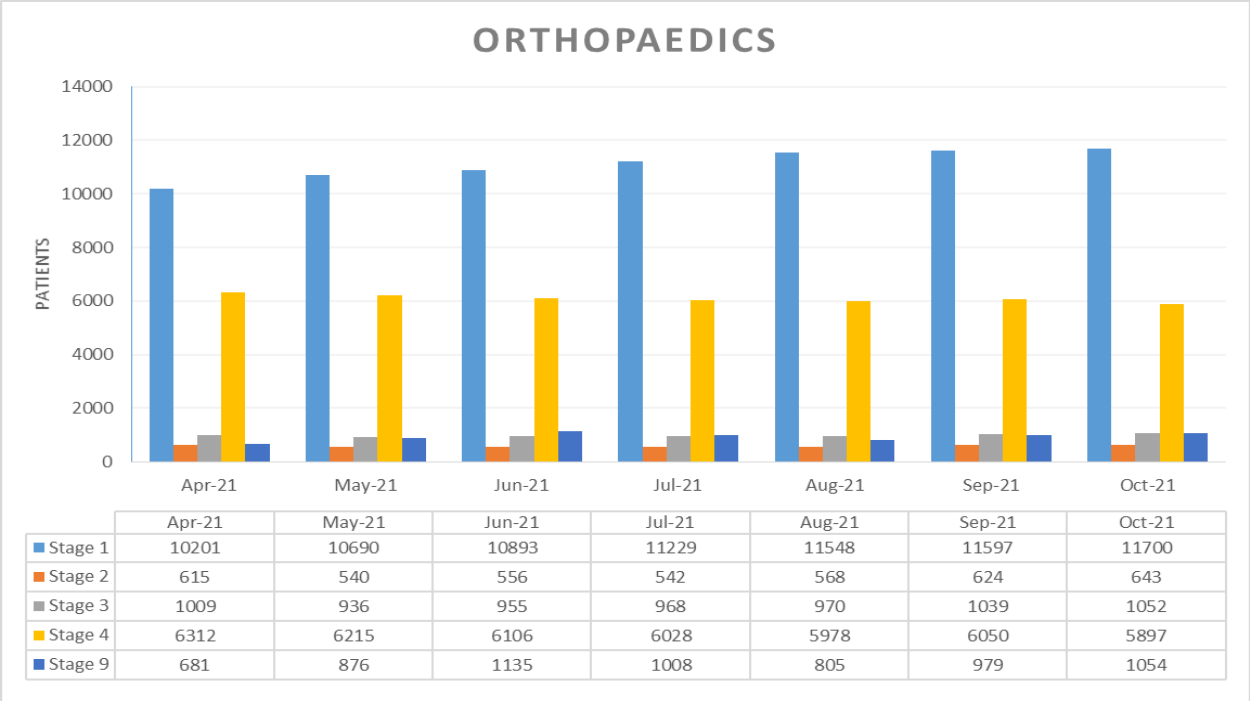
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	3943	4253	4709	5128	5293	5557	5906
Stage 2	21	22	34	48	64	71	59
Stage 3	667	572	628	531	604	634	650
Stage 4	2	0	1	1	1	4	1
Stage 9	856	815	1024	925	979	1032	820

Graph 2:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	5079	5233	5321	5430	5677	5881	6055
Stage 2	765	813	795	760	724	716	740
Stage 3	915	956	983	1023	1001	994	1008
Stage 4	2065	2060	2049	1912	1869	1940	1852
Stage 9	798	743	1029	998	841	902	1015

Graph 3:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	10201	10690	10893	11229	11548	11597	11700
Stage 2	615	540	556	542	568	624	643
Stage 3	1009	936	955	968	970	1039	1052
Stage 4	6312	6215	6106	6028	5978	6050	5897
Stage 9	681	876	1135	1008	805	979	1054

2.9 Following the unprecedented circumstances due to the pandemic and inevitable impact on waiting lists within all Health Boards across Wales, the Welsh Government initiated local Health Boards to undertake a large-scale tranche patient validation exercise at Stage 1 and Stage 4.

The Health Board sent out letters to all outpatients on the Stage 1 and Stage 4 a waiting lists (Waiting 48 weeks and over as of 30th June 2021). This was to determine if the patient's circumstances or needs had changed. Patients were asked to complete and return the questionnaire online.

We were advised during the review that in early meetings that took place to formulate the plan to undertake the WG initiated trance validation exercise, the managers on the sites have shared that they expressed concerns with the approach for the reasons of both clinical and administrative capacity and ability to maintain the activity using the methods provided

2.10 A presentation to the Planned Care Transformation Group on the 12th November 2021 provided an update on the stage 1 validation position.

Table 2: Initial Letters sent during period 05/07/21 – 13/08/21

Position as 11th November 2021

Total Records Validated	***20,112***	
Total Responded Remain	*12,544*	*62%*
Total Responded Remove	*2,143*	*11%*
Total Responded Non-responders	*5,280*	*26%*
Total Other (check required, deceased)	*145*	*1%*
Still Requiring Clinical Review/Review Outcome	*7,031*	*5%*
Of which, 'deteriorating statement'	*6,305*	*31%*

Total Records Validated	***20,112***	
Could be removed from waiting lists now	*1,926*	*10%*

2.11 The questionnaire included a 'deteriorating statement', asking if the patient believes they have deteriorated. 6,305 completed the deteriorating statement [for all sites]. The total number of patient responses who said yes for the specialties in our review as of the 11th November 2021 are:

- Urology – 630
- Dermatology - 323
- Trauma & Orthopedics – 1,755

We note that the lack of clinical capacity to review these patients to see if they should be expedited, against the competing priority of the re-purposing of any spare capacity to support the vaccination booster drive, has been logged as a tier 1 corporate risk at a score of 16 (ref.4260) on the 11th January 2022 and is awaiting Executive approval prior to the escalation process.

2.12 Figures detailed above were captured on governance spreadsheets for East, Central and West.

Details on the spreadsheet included, NHS number, patients name, patient contact details, Area, Case Reference Number (CRN), Unique Patient Identification (UPI), Consultant and specialty.

A temporary call centre consisting of shielding nurses and administrators was set up to receive the responses and populate the Governance spreadsheets. We are unclear how many individuals have access to populating the governance spreadsheets, so there is a risk that the data may be corrupted or deleted in error.

2.13 We combined all three governance spreadsheets and corroborated the data back to the total of 20,112 records validated. Using data interrogation software on the three spreadsheets we identified the following:

- Duplications – 1 duplication of the same patient within the same specialty (Trauma & Orthopaedics).
- 3 patients had the same unique patient identification (UPI) and NHS number (including 1 from Trauma and Orthopaedics).
- 51 records did not have a 10-digit NHS ID Number (Some were duplicates of Case Reference Number). This included 11 from our sample areas:
  - 3 urology
  - 6 Orthopaedics
  - 2 Dermatology
- One had a UPI No as a '6' (Urology)

- One with a duplicate NHS number, same name but different dates of births. (Not within our sample)
- Duplicate UPI number but two different names. (Trauma & Orthopaedics and Urology)

2.14 For those patients classed at stage 4, we were advised that all patients on the waiting list (patients who require routine surgery work) have required a refreshed waiting list, where each patient confirms they wish to actively remain on the waiting list.

2.15 With the Health Bard undertaking the stage 1 validation exercise manually, a business case has been developed for an automated validation tool within the Wales Patient Access System (WPAS).

The Head of Ambulatory Care along with technical colleagues are exploring plans to digitise and automate the patient validation process, to move away from tranche validation into BAU.

Following a meeting with WG leads 13th January 2022, there is an opportunity to seek national funding and deliver locally as a proof of concept to potentially be scaled up nationally.

2.16 Whilst this report does not explore the process undertaken in each site to undertake their specific functions for patient validation of waiting lists. We noted that validation activity in both Urology and Orthopaedics is managed by the respective site leads in Surgery, whilst Dermatology is managed by the Interim Assistant Director of Community Services.

2.17 We were provided with a document that sets out the rules for managing referral to treatment waiting times. The document provides a complete reference source of the waiting times management rules relating to the 26-week referral. This is followed by all three areas for the monitoring of waiting lists.

All three specialities take a comparable approach to the validation process. Weekly access meetings are held where they discuss:

- Follow up backlog,
- Long waiters list, and
- Risk stratification waiting lists.

These meetings feed into the overarching access meeting mentioned above.

Conclusion:

2.18 The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – other options should be reviewed to move away from a spreadsheet to a more stable application.

Evidence within the graphs shows little movement within the stages over the period stated.

Objective 3: Assessment of clinical risks relating to delays

2.19 The Royal College of Surgeons issued a reprioritisation code list and associated documentation where the onset of the pandemic meant many elective surgeries were cancelled. Following recommencement of elective surgery, a large proportion of these patients waiting were either approaching or had exceeded their 26-week target.

Patient risk stratification focuses on patient management of harm and alternative treatment regardless of which area the patient was receiving the treatment.

The table below details the groups and how patients requiring surgery have been classified.

Table 3:

Priority Level	Description
1a	Emergency - operation needed within 24 hours
1b	Urgent - operation needed with 72 hours
2	Surgery that can be deferred for up to 4 weeks
3	Surgery that can be delayed for up to 3 months
4	Surgery that can be delayed for more than 3 months

2.20 Clinicians risk stratify patients when they are listed for surgery and is record within the patient administration system for reporting. At present, the Welsh Patient Administration System (WPAS) is used within East and Central, with the West using Profile Information Management System (PIMS).

2.21 As of 31 January 2022, there were 25,086 admission pathways recorded across the Health Board. Twenty one percent (5,367) of these had not been risk stratified.

2.22 All three areas for Urology and Orthopaedics provided evidence that the patients on the waiting lists had been risk stratified. We received a spreadsheet for East and Central patients titled risk stratification waiting list reconciliation dated 25th October 2021. This document is presented to the local access meetings on a weekly basis. Whilst we can confirm that all patients had been risk stratified, we also noted that out of the 950 patients identified within the "Risk Strat/Reprioritised Status" 938 were classified as being overdue.

We have included the total number of admissions for Urology and Orthopaedics as at the 31st January 2022

- Urology 670, (6603 total admissions)
- Orthopaedics 105, (1501 total admissions)
- Other specialities on spreadsheet 163

2.23 The document highlighted all the elective priority levels that had been left blank for both specialties in East and Central. As well as differing risk

stratification priority scores within the sections of referral comments, elective priority score and risk stratification score.

2.24 We were informed by Dermatology that no risk stratification has taken place as they do not have any stage 4 patients.

Conclusion:

2.25 Evidence from the risk stratification waiting list reconciliation spreadsheet shows that patients within Orthopaedics and Urology have been risk stratified. **However, patients were highlighted as being overdue within the "Risk Strat/Reprioritised Status" section**, which could result in patient harm if they are not seen within the original timescale noted when first risk stratified.

There are conflicting risk stratification priority scores within the sections of referral comments, elective priority score and **risk stratification** score potentially leading to confusion, it is noted that the areas are aware of this and have highlighted it as an issue.

Consideration needs to be given to the potential for harm to the patient on both points above.

Objective 4: Patients removed from waiting lists

2.26 We were provided with evidence from the Informatics Department detailing all the patients removed from the waiting lists of the three specialties between April 2021 and October 2021.

2.27 The data was taken from WPAS and PIMS systems and included in-patients and out-patients. A further breakdown of the data including the reasons for removing patients from the list can be found in Appendix B

2.28 The table below, by specialty, details patients removed from the waiting lists in the period:

Table 4:

	Speciality		
Patient type	Urology	Trauma & Orthopaedics	Dermatology
In-Patient	1,405	2,104	1
Out-patient	1,565	2,349	47
Total	2,970	4,453	48

The review of data identified:

- There were 56 reasons in total for removing the patients.
- Reasoning for removal of patients between West compared to East and Central differ (we note that WPAS does not support the West removal codes).
- 378 patients had been entered in error.
- 788 patients had no reason recorded for being removed from the lists.

Conclusion:

2.29 Data is being recorded in all areas across the three sites, however we have identified issues of concern regarding the patients included in error and those with no reasons recorded – management should undertake a follow-up review to confirm the accuracy of this data.

Standardisation of the reasons to remove patients should be developed to ensure consistency across the Health Board.

Appendix A: Management Action Plan

Matter Arising 1 - WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	Impact
There is a *governance* spreadsheet in place which contains the details of all patients who are awaiting an Outpatient appointment and have been validated. At the time of the review over 20,000 patients were recorded on this spreadsheet. We were unable to ascertain who has access to and who is populating the governance spreadsheet. We also found the following • Duplications – 1 duplication of the same patient within the same specialty (Trauma & Orthopaedics). • 3 patients had the same unique patient identification (UPI) and NHS number (including 1 from Trauma and Orthopaedics), • 51 records did not have a 10-digit NHS ID Number (Some were duplicates of CRN No's), this included 11 from our sampled areas: • 3 urology • 6 Orthopaedics • 2 Dermatology • One had a UPI No as a '6', • One duplicate NHS number had the same name but different date of births, and • One had the same UPI number but two different names.	The integrity of the data on the governance spreadsheet cannot be determined, which could result in patients not being contacted or details being incorrect.
Recommendation	**Priority**

The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application	High	
Agreed Management Action	**Target date**	**Responsible Officer**
This report audits information on **ONLY** the one-off WG initiated tranche patient validation (not the standard patient validation carried out within each site as part of their core functions) – it is not expected that this will be repeated in this way again; this report will support the lessons learnt that was carried out on that one-off initiative that has informed the improvements in patient validation. On the 10th December 2021, the patient activity was safely closed down, the spreadsheets locked to 'read only' on the SharePoint site and downloaded by the Head of Ambulatory Care. To manage the remaining activity based on the patient responses, the spreadsheets were split into manageable cohorts of data and handed over to named individuals in the PABC to disseminate the remaining work. Much of the work has completed now with the remaining outstanding areas of work pertain to (i) adding validation markers and (ii) clinical validation of the patients that requested to remain & provided a 'deterioration statement'; both of which have been picked up in the latest validation cleanse activity (Step 1 and Step 2 below) **Action 1** – Cleanse the Waiting Lists	**Action 1 –** 31/07/2022	Head of Ambulatory Care

Steps	
Step 1	Tidy up validation markers in PAS post S1 Tranche Validation Exercise

	Step 2 – Complete the post S1 Tranche Validation Exercise work to clinically validation patients that requested to remain & provided a 'deterioration statement' Step 3 – Undertake cleanse of 'duplicates' on the waiting lists Step 4 – External Validation: Task 1 –run our PTL data through their validation software to report on findings Task 2 – phone contact - validation of all patients >36wks and un-validated S1 and S4 Task 3 – pathways validation to be defined based on the output from Task 1.		
Action 2 - Project to Automate & Digitise the Patient Validation Exercise - This project will use digital transformation in conjunction with process redesign to deliver significant and tangible improvements, removing much of the administration function – moving patient validation into business as usual rather than cohort or tranche activity. Phase 1 will be a proof of concept with one or more specialities. Funding is being sought via the WG who have engaged on the initiative with a view to scaling up pan-BCU		**Action 2** – 30/09/2022 (funding dependant)	Head of Ambulatory Care
Action 3 - Review and redesign the Service Validation Models pan-BCU		**Action 2** – 31/03/2023 (funding dependant)	Head of Ambulatory Care

Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Impact	
Evidence from the risk stratification waiting list reconciliation spreadsheet shows that patients within Orthopaedics and Urology have been risk stratified. However, the patients were highlighted as being overdue within the "Risk Strat/Reprioritised Status" section. • Urology 670 (6603 total admissions) • Orthopaedics 105 (1501 total admissions) • Other Specialities on spreadsheet 163 There are conflicting risk stratification priority scores within the sections of referral comments, elective priority score and risk stratification score potentially leading to confusion, it is noted that the areas are aware of this and have highlighted it as an issue.	Patients are not risk stratified when due, which could lead to deterioration and potential harm to patients.	
Recommendation	**Priority**	
Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm	High	
Agreed Management Action	**Target date**	**Responsible Officer**
This pertains to the risk stratification of patients on the stage 4 waiting lists. Patients are referred into our waiting lists from GPs as either urgent or routine. The patient is then triaged and confirmed as urgent or routine prior to 1st appointment. At 1st appointment the patient is considered for surgery and risk stratified in line with the Royal College of Surgeons guidance as P1-P4, when the patient joins the Stage 4 waiting list.		Site Directorate General Managers

As at 10th March 2022 the data across all sites shows by speciality the number of patients where the P value is 'unknown' i.e. not entered into the PAS is as follows: ▪ T&O – 298 ▪ Urology – 150 ▪ General Surgery – 21 ▪ Breast – 24 ▪ Colorectal – 58 ▪ UGI – 18 ▪ Vascular – 108 ▪ ENT – 56 ▪ Max Fax - 28 As the focus of this internal audit report highlighted T&O and Urology; with these two specialities making up 64% of all patients without a P value in the PAS, these will be prioritised, followed by the remaining specialities to achieve the following actions:		
Action 4 – Validation of missing risk stratification data at an *individual patient level* (i.e. patients with unknown P value where the 1st appointment has already been held and where the PAS has not yet been updated) with planned review including informatics team pulling a live report in readiness for 30th April 2022.	**Action 4**- 30/04/2022	
Action 5 - In line with generic admin processes, each site will work to ensure that for those patients that have received their 1st appointment and are awaiting surgery, a P value will be entered into the PAS within 6 weeks of that 1st appointment.	**Action 5** – 31/05/2022	
Action 6 – Progress will be monitored locally on each site through a standing item at the weekly site *Access Meetings* to ensure the progress in action 4 is maintained	**Action 6 -** 31/03/2022	

Action 7 – Pan-BCU progress will be reviewed and monitored monthly at the Planned Care Operational Meetings to ensure the progress in action 4 is maintained	**Action 7 -** 31/03/2022	

Matter Arising 3 - Patients removed from waiting lists (Operation)	Impact	
Information on patients removed from waiting lists was extracted from the respective Patient Administration Systems for East, Central and West. The wording of the reasons is slightly different between the systems, making it difficult when merging reports as well as potentially confusing for those who are inputting the reasons. We identified: • 378 patients had been entered in error • 788 patients had no reasoning provided for being removed from the lists (these were categorised as "Null" and "Unspecified")	Potential for miss-reporting	
Recommendation	**Priority**	
Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Medium	
Agreed Management Action	**Target date**	**Responsible Officer**

WPAS Central is the nationally hosted instance into which 'West PIMS' and 'East WPAS instance' data will be moved over to (project full end May 2023). Whilst we cannot risk any delays to the West implementation which is due in May 2022, there is opportunity to standardise the codes on East WPAS earlier than their planned migration in 2023. The following actions reflect this:		
Action 8 – West Standardisation: WPAS West implementation is due to go live 16th May 2022 and this will standardise the removal reasons with the Central WPAS instance	**Action 8** May 2022	WPAS Standardisation lead
Action 9 – Ahead of the East migration to the Central WPAS instance, the codes will be standardised in the East WPAS instance tables to align with the Central WPAS removal codes.	**Action 9** July 2022	WPAS Standardisation lead
At this point the removal codes for all patients pan-BCU will be standardised.		

Appendix B: Out-Patients and In-Patients Reasons for removal from Health Board Waiting List

AREA	Out-Patients

Row Labels	Urology	Trauma & Orthopaedics	Dermatology
Appointment Inconvenient		1	
C.N.A & discharge	18	15	
Cancelled by GP	12	1	
Cancelled by GP or Cons	1		
Cancelled by Health Authority	1	10	
Cancelled by Hospital	40	142	2
Cancelled by patient	60	70	
Clerical error	30	23	
Conditioned Resolved	4	2	
Did not attend & Patient Discharged	18	192	1
Died (before appointment)	7	3	
Discharged by Consultant	12	1	
Discharged following consultant decision		1	
Entered in error	46	115	3
Inappropriate Referral	195	368	9
Moved to Treatment waiting list	397		
NHS Patient seen as Private	43	66	
No response to partial booking letters	4	10	
NULL	7	12	
Outpatient Attendance	96	8	
Patient cancelled repeatedly	1	1	
Patient did not attend	9	2	
Patient did not phone	59	135	30
Patient died	72	76	1
Patient failed to opt-in		1	
Patient moved away from area	4	7	
Patient no longer requires treatment	15	12	
Patient no longer traceable	1	1	
Patient no longer wants treatment	29	26	
Patient treated at a Private Hospital	8	26	
Patient treated at another NHS Trust	3	4	
Patient treated at this Trust	15	58	
Referred to GP - LHB ruling		1	
Refusal of reasonable offer	5		
Removed - INNU		30	

Removed - Insufficient referral information	18		
Removed - Lifestyle	1		
Removed after validation - Consultant request		10	
Removed discharged back to care of GP	3		
Removed unavailable ref to other consultant	1		
schedule	2	1	
Seen at other hospital	8	164	
Seen at treatment centre		10	
Seen via emergency admission	9	3	
Seen via other treatment	145	170	
Telephone Contact	2		
Transferred to Inpatient/Daycase waiting list	19	2	
Treatment no longer required	145	569	1
Grand Total	**1565**	**2349**	**47**

AREA	**In-Patients**

Row Labels	**Urology**	**Trauma & Orthopaedics**	**Dermatology**
Appointment Inconvenient	3		
C.N.A & discharge	2	1	
Cancelled by GP		1	
Cancelled by GP or Cons	4	2	
Cancelled by Health Authority	2		
Cancelled by Hospital	189	238	
Cancelled by patient	90	166	
Clerical error	8	5	
Conditioned Resolved	10	4	
Did not attend & Patient Discharged	3	3	
Died (before appointment)	7		
Discharged by Consultant	3	2	
Discharged following consultant decision	1	5	
Domiciliary		1	
Entered in error	43	105	
Inappropriate Referral	1	3	
Moved to Treatment waiting list	13		
NHS Patient seen as Private	15	39	
Not Specified	433	332	
NULL	2	2	
Outpatient Attendance	1	1	
Patient cancelled repeatedly	1	1	
Patient did not attend	14	7	
Patient did not phone	3	20	
Patient died	115	53	1
Patient failed to opt-in	79	46	

Patient moved away from area	2	12	
Patient no longer requires treatment	52	102	
Patient no longer traceable	2	8	
Patient no longer wants treatment	86	133	
Patient treated at a Private Hospital	5	67	
Patient treated at another NHS Trust	8	14	
Procedure not wanted by patient	1		
Refusal of reasonable offer	10	3	
Rejected - lack of capacity		1	
Removed after validation - Consultant request	3	4	
Removed after validation - no response	5	79	
Removed after validation - patient request	2	97	
Removed discharged back to care of GP	1		
Removed unavailable social	2	9	
Removed unavailable unfit	3	20	
Seen at other hospital	23	90	
Seen at treatment centre		68	
Seen via emergency admission	7	18	
Seen via other treatment	28	114	
Transfered to Inpatient/Daycase waiting list	5		
Treatment no longer required	118	228	
Grand Total	**1405**	**2104**	**1**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Clinical Audit

Final Internal Audit Report

April 2022

Betsi Cadwaladr University Health Board

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

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

Contents

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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

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Executive Summary

Purpose
This purpose of this review was to evaluate and determine the adequacy of the systems and controls in place for the planning and completion of clinical audits.

Overview
We have issued limited assurance in this area. The significant matters which require management attention include:

- Policy/Procedure document requires a review and a governance structure needs to be entered under appendix 1.
- There is no evidence that the appropriate information has been reviewed to ensure the Clinical Audit Plan is risk focused i.e. incidents, complaints, never events. There is no formal risk assessment to support the rationale for Tier 2 audits.
- Quarterly reports reflecting progress against the Clinical Audit Plan have not been regularly received at the overarching Clinical Effectiveness Group (CEG) or Quality, Safety and Experience Committee as a result of meetings being stood down due to COVID.
- Timelines for completion and returns of Welsh Government National clinical audit proformas A and B are generally poor and not being met, including the non-completion and submission of forms.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	There is a policy and process in place for clinical audit.	Reasonable
2	The annual Clinical Audit Plan, which includes Tier 1 (national) and Tier 2 (local priority) audits, is developed through an appropriate forum, is based on the organisational risks or concerns that have been identified and has been approved by the relevant Committee.	Limited
3	Progress against the Clinical Audit Plan is reviewed regularly by an appropriate forum and, where applicable, feedback is given to the clinical leads responsible for each audit.	Limited
4	Results of clinical audits are fed back to the appropriate clinical forums, management groups and committees.	Limited
5	We will also consider the arrangements in place for a sample of Tier 3 (local) audits, including whether these are registered.	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Assurance objective	Control Design or Operation	Recommendation Priority
1	The Clinical Audit Policy requires review and updating.	1	Operation	Medium
2	There is a lack of evidence to demonstrate the Clinical Audit Plan has been developed through effective review of organisational risks and other key areas such as incidents, never events etc.	2	Operation	High
3	Progress reports are not being regularly received within the appropriate forums/committees (note this has been impacted by meetings being stood down).	3	Operation	High
4	There is a lack of evidence to demonstrate feedback and learning from clinical audit reports.	4	Design / Operation	High
5	There is a lack of evidence to justify the inclusion of audits on Tier 3 plans and sharing of feedback / lessons learned from Tier 3 audits.	5	Design / Operation	High

1. Introduction

1.1 The review of Clinical Audit was completed in line with the 2021/22 Internal Audit Plan. The review sought to provide Betsi Cadwaladr University Health Board (the 'Health Board') with assurance that there are effective processes in place to embed a culture of clinical audit best practice, and continuous quality improvement in its services. The relevant lead for the assignment is the Medical Director.

Clinical audit is designed to improve patient outcomes across a range of medical, surgical, and mental health conditions. Its purpose is to:

- Engage all healthcare professionals in systematic evaluation of their clinical practice against their respective standards and to support and encourage improvement in the quality of treatment and care.
- Provide information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

1.2 The potential risks considered in this review were as follows:

- Patient outcomes are not improved.
- Failure to undertake mandatory national audits.
- Local risk areas are not identified and incorporated into the plan.
- Action is not taken to address identified issues.

1.3 The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place in relation to the planning and reporting mechanisms for clinical audits.

The areas reviewed focused on the following:

- There is a policy and process in place for clinical audit.
- The annual Clinical Audit Plan, which includes Tier 1 (national) and Tier 2 (local priority) audits, is developed through an appropriate forum, is based on the organisational risks or concerns that have been identified and has been approved by the relevant Committee.
- Progress against the Clinical Audit Plan is reviewed regularly by an appropriate forum and, where applicable, feedback is given to the clinical leads responsible for each audit.
- Results of clinical audits are fed back to the appropriate clinical forums, management groups and committees. Where actions are identified, plans are put in place to address these issues and lessons learned are communicated.
- We assessed arrangements in place for a sample of Tier 3 (local) audits, including whether these are registered, results are communicated and actions are followed up.

2. Detailed Audit Findings

Objective 1: There is a policy and process in place for clinical audit.

2.1 We were provided with the *MD22 - Clinical Audit Policy & Procedure* which can be found on the Health Board intranet site and was approved on the 28th January 2020 via the Quality, Safety and Experience (QSE) Committee. The policy/procedure was due for review in March 2021.

We are advised that due to the COVID pandemic the policy was not formally communicated to staff and this is planned for the future.

2.2 The policy/procedure sets out the process for undertaking clinical audits, encompassing the Welsh Government mandated audits (Tier 1), local priority audits based on Health Board priorities and risks (Tier 2) and arrangements in place for Tier 3 (local) audits.

2.3 Section 7 of the policy/procedure refers to appendix 1 and the governance structure, however appendix 1 states that the governance structure is currently under review.

Conclusion:

2.4 A policy and procedure document is available on the Health Board intranet site, however the document is overdue for review and needs to be updated to reflect current governance structures. We were informed that an updated draft has been completed and is subject to consultation. The policy has also not been formally communicated to staff.

Objective 2: The annual Clinical Audit Plan is developed through an appropriate forum

2.5 The Corporate Clinical Audit Annual plan has not changed significantly over the last two years due to the impact of the COVID-19 pandemic. The Tier 1 clinical audits are mandated by Welsh Government or other regulatory bodies such as Medicines & Healthcare products Regulatory Agency (MHRA).

2.6 Tier 2 audits are those considered necessary at a corporate level because of their risk profile or requirement to improve. These audits may be undertaken within the local services or through the clinical effectiveness department; the majority are completed within the services.

The Clinical Audit Plan for 2021/22 includes thirty-two (32) Tier 2 audits. All the audits were classified within one or more of the six criteria highlighted with the audit plan spreadsheet:

- Internal /external guidance
- Corporate policy
- External review
- Re-audit/continuous
- Risk Register
- Claims Audit

As well as an explanation of what objectives are being met, these include reference to National Institute for Health and Care Excellence (NICE) guidelines.

All Tier 2 audits were given a risk assessment classification based on criteria within the spreadsheet (critical, high, medium, low). We have not seen any further evidence of formal assessment which would explain the rationale for assigning the classification criteria to audits.

We do note that eight of the audits are linked to the criteria of risk register (local) where there is an expectation to see an assessment underpinning the reason for it to be entered onto the register.

2.7 We note that the Clinical Effectiveness Department contacts areas for their suggestions for Tier 2 audits, however we have not been provided with evidence to demonstrate whether there is a review of wider information such as the Corporate Risk Register, incidents, complaints, never events, patient feedback etc. to inform the plan and to ensure it is addressing risks highlighted within the Health Board.

2.8 The draft Clinical Audit Plan for 2021/22 was presented to the Audit Committee on the 10th June 2021 with approval being granted noting the following:

Draft Public Minutes Audit Committee 10th June 2021 AC21.32.6

That the draft Clinical Audit Plan for 2021/22 be approved noting that the Plan was to be presented to the Quality, Safety and Experience Committee in July at which there would be further discussion on the Tier 2 audits and the learning and communication of learning from Tier 3 audits.

2.9 The draft Clinical Audit Plan for 2021/22 can be seen being presented to Quality, Safety and Experience Committee meeting on the 6th July 2021 as well being approved as a working document within the minutes.

Minutes of the Quality, Safety and Experience (QSE) Committee Meeting Held in public on 6.7.21

QS21/107.4 It was resolved that the Committee approve the draft Clinical Audit Plan 2021/22 as the current working document.

Evidence can be seen within the minutes on a discussion taking place regarding an appendix that had been included for the Quality, Service and Experience Committee concerning Tier 3 audits to work towards the ability to consider whether some needed to move up to Tier 2.

There is no evidence in the minutes that there was discussion on the Tier 2 audits and the learning and communication of learning from Tier 3 audits, as stated at the Audit Committee (see 2.5 above).

2.10 On the 26th January 2022 an email was circulated to all services requesting the need for the Tier 2 audits for the Audit plan 2022/23.

A systematic approach is recommended by the Clinical Effectiveness Department to be used as per policy, this enables the multidisciplinary teams to prioritise and agree upon topics for inclusion within the plan:

- frequency ('how often' or 'how many'?).
- degree of risk (likelihood of something going wrong or not being done).
- level of concern (how important is the question?).

- outcome (what is the impact in relation to potential for improvement/harm?).

The Email also quotes from the policy requesting all Tier 2 audits should:

"support delivery of the Quality Improvement Strategy goals and priorities, including accreditation requirements specific to the service, NICE guidance compliance, safety audits, audit related to high-risk activity and corporately agreed service improvement priorities".

2.11 On the 3rd February 2022 a reminder email was sent which included offers of support from the Clinical Effectiveness Team through: -

- signposting to the intranet page.
- sign post to weekly clinical effectiveness clinics.
- corporate team generic in box.

We were also provided with an email from the Office of the Medical Director sent on 3rd February 2022 to the two-deputy medical director(s) enlisting their support to promote the requirement for Tier 2 audit plans.

We were provided with the Tier 2 audit plan and evidence that this was circulated to the members of the Clinical Effectiveness Group for discussion at the meeting. This included a summary of responses above.

Conclusion:

2.12 The Audit plan for 2021/22 was agreed at the appropriate committees. Whilst Tier 1 audits are nationally mandated, Tier 2 audits are those that are *considered necessary at a corporate level because of their risk profile or requirement to improve.* We note that the Clinical Effectiveness Department contacts areas for their suggestions, however we have not been provided with evidence to demonstrate whether there is a review of wider information such as the Corporate Risk Register, Incidents, Never Events, patient feedback etc.

2.13 Tier 2 audits included in the plan have been allocated a risk assessment classification based on criteria within the audit plan spreadsheet. However, we did not see seen any evidence of formal risk assessment which clarifies the rationale for assigning the classification criteria to audits.

2.14 The planning for the 2022/23 Clinical Audit Plan was not progressed enough at the time of testing to demonstrate the justification for audits being included in the plan.

Objective 3: Progress against the Clinical Audit Plan is reviewed regularly by an appropriate forum

2.15 It should be noted that a number of Clinical Effectiveness Group meetings (both overarching and local) throughout the year were cancelled due to COVID-19, which has impacted on reporting to Committees.

2.16 We reviewed the papers for the following Audit committee meetings:

- 17th December 2020
- 18th December 2021

- 10th June 2021
- 28th September 2021
- 14th December 2021

The request for the approval of the 2020/2021 audit plan was discussed at the meeting of 17th December 2020. The draft plan was first presented in March 2020, however, at the time Clinical audit had not received official notification from Welsh Government confirming the Tier 1 audits.

The audit plan for 2021/2022 was presented for approval on the 10th June 2021 and was subsequently approved. The Audit plan for 2022/2023 was due to presented to the Audit Committee on the 15th March 2022 in accordance with the cycle of business, however a verbal update was provided and no plan was presented.

2.17 We reviewed the papers for the following Quality Safety Experience committee meetings:

- 2nd March 2021
- 4th May 2021
- 6th July 2021
- 7th September 2021
- 2nd October 2021
- 2nd November 2021
- 11th January 2022

The 2020/2021 audit plan was agreed on the 6th July 2021. The Clinical Audit Annual Report was presented at the meeting of 2nd November 2021.

Audit Committee 10th June 2021

AC21.32a Clinical Audit Plan 20212022 front cover 3.6.21 AG.docx

Background:

Clinical Audit has an annual planning cycle, although many audits are continuous across the year. There is quarterly reporting to Quality, Safety and Experience Committee on progress against the plan, with an annual report at year end to the Joint Audit Quality Safety Committee.

We have not been able to evidence the quarterly reporting to the Quality, Safety and Experience Committee within the minutes of the meetings.

2.18 The overarching Clinical Effectiveness Group (CEG) should provide a forum where clinical audit and service evaluation is discussed. It occurs bi-monthly however we note some meetings were stood down in 2021 due to operational COVID pressures:

- 19th August 2021
- 14th December 2021

We received the minutes for all the Clinical Effectiveness Group meetings that had taken place throughout 2020 and 2021.

The Clinical Audit Policy & Procedure MD 22, section 8.6 states: *The Clinical Effectiveness department will produce quarterly annual plan monitoring reports for the Clinical Effectiveness Group. These reports will be cumulative,*

building to an annual report that will be received by the Joint Audit & Quality Committee in November each year.

We requested last three quarterly reports to Clinical Effectiveness Group in order to evidence clinical audit evaluation:

- We received evidence of an annual report for 2020/2021 presented to the Quality Safety and Experience Committee on the 2nd November which incorporated the Quarter 4 report.
- The Quarter 1 2021 report was presented to the October 2021 Clinical Effectiveness Group. We were informed that the delay was due to gap in management cover for the clinical effectiveness team as well as cancellation of Clinical Effectiveness Group meetings due to COVID.
- We have been informed that Quarter 2 and Quarter 3 reports will be merged and presented to the Clinical Effectiveness Group meeting on the 10th February 2022. We have received the reports however we have not been able to evidence presentation at the Group due to the minutes not yet being available.

It should be noted that these quarterly reports do not appear in the terms of reference of the meeting, presented on the 10th February 2021. The Cycle of Business includes 'Clinical Effectiveness' but does not specify quarterly reports are to be provided.

2.19 Having viewed the most recent cycle of business, as part of the assurance provision it identifies that Clinical Improvement and Audit Sub-group for East, Central and West should be providing Triple A Report (Alert, Assurance, Achievement) to the Clinical Effectiveness Group.

Submission of these reports should have occurred during the meetings of 19th August and 14th December which did not take place. Therefore, we have been unable to see evidence of the Clinical Improvement and Audit Sub-groups reporting into the Clinical Effectiveness Group for the year of 2021.

The meetings mentioned in the above cycle of business have now been replaced with local Clinical Effectiveness Groups within East and Central, whilst West have merged the quality, safety and clinical effective functions within the same meeting and is now entitled the Quality, Safety and Clinical Effectiveness Group Meeting.

2.20 We requested the last three sets of minutes for the area local Clinical Effectiveness Groups, which we received from all three areas. A number of these meetings were stood down due to COVID.

All minutes that were provided demonstrated evidence of discussions taking place within the area meetings on Tier 1 activity. We can also evidence an assurance report provided to the West Quality, Safety and Clinical Effectiveness Group Meeting on the 11th January 2022. We were informed that this report was considerably shorter than normal, with content reduced at the request of the Chair due to reduced meeting scope due to Covid.

2.21 The Health Board has purchased an Audit Monitoring and Tracking (AMaT) software which records and monitors national, corporate and local audit information and NICE guidance compliance.

AMaT was launched in April 2021 and is currently being piloted within Women's Services with a view to potential Health Board roll out in 2022; however this is contingent upon required staff resource to implement.

Conclusion:

2.22 There is evidence to demonstrate the annual Audit Plan and the annual report are presented to the Audit and Quality, Safety and Experience Committees. However, no other reports reflecting progress against the plan can be seen going to either Committee throughout the year as a number of meetings were stood down due to COVID.

2.23 Quarterly reports and the annual report can be seen going to the overarching Clinical Effectiveness Group from the clinical effectiveness department, although Quarter 2 and Quarter 3 reports have been issued together on the 10th February 2022 (this meeting was not quorate); there has been no regular reporting throughout the year, which has been impacted due to meetings being stood down during COVID.

2.24 The cycle of business for the overarching Clinical Effectiveness Group needs updating to reflect the requirement for quarterly reports. We are advised this has been actioned following completion of fieldwork, with a draft cycle of business (copy provided) circulated for comment.

2.25 No reports from the local Clinical Effectiveness Groups can be seen going to the Clinical Effectiveness Group as per cycle of business due to the cancellation of meetings.

Objective 4: Results of clinical audits are fed back to the appropriate clinical forums, management groups and committees.

2.26 The annual report 2020/21 was presented to the Quality and Safety Experience Committee on the 2nd November 2021. This report included progress against the three Tiers of audits and included the following information:

2.27 **Tier 1**

- From twenty-seven (27) Tier 1 audits undertaken the Health Board achieved 37% where the Health Board's performance benchmarks against All Wales/and where relevant UK peers were above 75% or more.
- 33% where the Health Board's performance benchmarks against All Wales/and where relevant UK peers were in-between 50% - 75%.
- As a point of note it is specified that the figures within above are achieved by the following methodology

  Clinical Audit Annual Report 2020/21

  i.e. if there are 10 measures/standards in the audit. There are 3 opportunities to achieve each standard when applied to the acute sites in BCUHB so the denominator is 3x10 = 30 Suppose the sites achieve the

national averages or standards in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCUHB there were 10 (3+4+3)/30 opportunities to meet or surpass the national average - 33% compliance has been achieved.

Using the same methodology below we could achieve the same results by using overall performance rather than site performance. YG achieves 10/10 YGC achieves 0/10 WMH achieves 0/10 = 33% compliance, however two areas have achieved no compliance.

2.28 We note the methodology above appears one which could favour a positive outcome and may provide overly positive assurance with regards to compliance if this is not measured by site. Whist an overall score may be required for reporting to Welsh Government, and we note that issues by site are included in the report, we consider and believe site compliance scores must also be reported to ensure the Health Board is sited on areas of low compliance / concerns.

2.29 Tier 1 Welsh Government national mandated projects are expected to complete a two stage proforma (Part A, B). The proforma includes the improvement plans and any progress between data collection and reporting. Usually in accordance with policy the proforma is required to be returned to Welsh Government within 4 weeks. However due to COVID pressures the timeframe has been extended, part A should be completed within 8 weeks and part B within 16 weeks.

For the year 2020/21 out of 26 audits:

- Part A: Thirteen (50%) were returned within the COVID deadline; Ten (39%) were returned after the COVID deadline with three (11%) not being returned at all.
- Part B: Thirteen (50%) were returned within the COVID deadline; Eight (21%) returned after the COVID deadline with five (19%) not being returned at all.

2.30 We are advised that exception reports to the local East and Central CEGs and the West Quality, Safety and Clinical Effectiveness Group Meeting have been introduced as a process for monitoring and escalating delays in Part A and B responses. We were provided with examples of these reports and a submission of exceptions to the November 2021 overarching Clinical Effectiveness Group.

2.31 **Tier 2**

Thirty-eight audits took place of which eighteen (47%) were completed; fourteen (37%) were still in progress; and six (16%) delayed.

2.32 **Tier 3**

Four hundred and thirty-three (433) projects were registered of which fifty-three (12%) were completed.

2.33 The quarter 3 report for 2021/22 was presented to the CEG on the 10th February 2022, highlights include:

- there are currently nine-part A proformas due with only two received and seven overdue.
- there are currently five-part B proformas due with only one received and four overdue.
- of the sixteen audits it was stated that fifteen of the audits had action plans in development (we have not corroborated this assertion).
- Tier 2 – thirty-eight audits in total; twenty-five in progress, on schedule or completed with thirteen delayed with evidence of actions to bring the review back on track.

2.34 Within the minutes of the local Clinical Effectiveness Groups in East and Central as well as the minutes of the quality, safety and clinical effectiveness meeting in the West, Assurance reports presented give an update on the progress on Tier 1 and Tier 2 audits.

2.35 Health check meetings between the Clinical Effectiveness Department and divisions have recently been introduced. These meetings include clarifying and confirming how they are using their audit results. An example given was a health check meeting with the Cancer division on the 16th February 2021 - they have identified that they used Clinical Advisory groups to consider the results of the audits.

2.36 There is a requirement that divisions use their local governance processes and clinical teams to identify required improvement, consider the audit results, actions required, and monitor these until completion, then reviewing progress through the subsequent audit cycle.

There are a number of forums that they may use for this, listed below:

- Clinical team / local clinical network discussion
- Team and / or professional meetings
- Divisional Clinical advisory groups (CAGS) and / or Clinical effectiveness groups
- Divisional Governance meetings

Conclusion:

2.37 There is some evidence of results being fed back through Health Check meetings, although these have only been introduced recently. The ability to undertake these meetings has been restricted by the resource available within the Clinical Effectiveness Department.

2.38 Feedback provided to the Quality, Safety and Experience Committee and Clinical Effectiveness Group meetings focused on progress and completed actions. We did not see evidence of regular feedback and lessons learned being shared across the Health Board. We are advised this has been impacted by the number of meetings being cancelled.

2.39 Timelines for completion of Tier 1 audits and the return of proformas A and B to meet deadlines is poor and requires immediate focus and improvement. We are advised that the Clinical Audit & Effectiveness Team does not have sufficient resource to be able to support divisions/areas with completion of audits. A Business Case was submitted in September 2021 to provide

additional resources for the Clinical Audit and Effectiveness Team in order to be able to deliver the Clinical Effectiveness Agenda, including support to divisions / areas to complete audits, this is currently at 'priority 2'.

2.40 Exception reports are now being provided to the overarching Clinical Effectiveness Group, local East and Central CEGs and the West Quality, Safety and Clinical Effectiveness Group Meeting in order to improve compliance.

2.41 The methodology adopted for Tier 1 compliance reports appears one which could favour a positive outcome and may provide false assurance on compliance if this is not measured by site.

2.42 It should be noted that there is currently a risk on the Office of the Medical Director Risk Register *"There is significantly reduced capacity within the Clinical Audit and Effectiveness (CA&E) Department. The department is now unable to deliver some elements of the CA&E agenda. The risk is that the Health Board will not provide sufficient assurance internally or externally about the quality of services; quality and safety may be compromised if audits are incomplete or deferred…".*

Objective 5: Arrangements in place for Tier 3 audits

2.43 The Clinical Audit Policy states: *All Tier 3 projects must: be registered with the Clinical Effectiveness Department accessed through a self-registration audit tool for registering Tier 3 has been developed.*

2.44 A self-registration database was developed and launched in August 2020; a link is provided within the policy to the online Clinical Audit Registration. Locally initiated audits are undertaken within specialties and departments by local agreement. Project leads self-register their audits and upload completed audit reports. We are not aware that this list of audits is shared wider i.e. with divisions, to avoid duplication of audits / resources, however the Business Case referred to above includes additional resources to deliver this going forward.

2.45 The audit is considered closed when the audit report has been uploaded. There is no evidence that these reports / findings are shared wider across the Health Board.

2.46 There is no oversight of the Tier 3 audits being undertaken across the Health Board and progress is not reviewed centrally or included in the reporting to Quality, Safety and Experience Committee. We were informed that responsibility for Tier 3 activity was delegated to divisions by the Medical Director in 2019 due to a lack of resources within the central team.

2.47 We received a clinical effectiveness exception report taken from the self-registration data. The report data was from August 2020 until December 31st 2021. We looked at all the data from the 1st April 2021 until the 31st December 2021 and we noted the following: -

- Two hundred and seventy-eight (278) Tier 3 audits had been registered since the 1st April 2021.
- Forty-six (17%) of the 278 registered audits were complete, with two hundred and thirty two (83%) ongoing.

- All audits had the full name and job title of the applicant.
- One hundred and thirteen (41%) of the audits had "other" as the main reason why the project is required; this is a drop-down section when completing the self-registration. Thirty-one (27%) had either N/A or no comment in the reason why the audit is required – Consequently we are unable to corroborate the rationale/justification why these clinical audits are being undertaken.
- All 278 had the name, approver designation and approver lead department. Although we have been unable to determine if the approver is a Divisional/Directorate or Primary Care Lead as stated within the policy. We do note there is a tick box when completing the online registration and no space for confirming the name if the approver:

  "*Please confirm you have gained prior approval from your Audit Lead or Educational Supervisor and that they have reviewed the topic and proposed methodology*"

  We are advised that this is an interim measure pending full implementation of AMaT.
- Per the policy, all Tier 3 audits should be risk based. We have been unable to evidence any description of risks/risk assessment justifying the registration audits.

Conclusion:

2.48 Reasons for why Tier 3 audits are required should be reviewed to ensure here is justification in at least one of the two sections that require a reason. The uploading of an assessment for each audit would further strengthen the reason/justification for undertaking the audit.

2.49 Whilst the responsibility for Tier 3 audits sits with divisions, there is a lack of oversight of these across the Health Board, risking duplication of audits within divisions. We are advised that the plan has since been reviewed against the risk register. We are also advised '*Due to local lack of assurance that the risk registry clearly and solely articulates the high risk areas, here is continued focus on consultation with localities in addition to identifying the high level risks described on the risk register'*

2.50 There does not appear to be a process operating to ensure that lessons learned and feedback from Tier 3 audits are shared more widely. Whilst we note that the Clinical Effectiveness Department has started Health Check meetings with divisions, it is important that this information is shared across the Health Board to maximise opportunities for learning and change.

Appendix A: Management Action Plan

Matter Arising 1 – Clinical Audit Policy (Operation)	**Impact**	
A policy and procedure document MD22 is available on the Health Board intranet site, however the document is overdue for review and requires a governance structure to be included in appendix A.	Policy not reflective of current practice.	
Recommendation	**Priority**	
1.1 Review and update the policy and procedure document MD22, and include the governance structure (pending outcome of governance review) within Appendix 1.	Medium	
Agreed Management Action	**Target date**	**Responsible Officer**
Management comment **Awaiting release of final operating model**. The updated policy has been held in draft form, since September 2021, awaiting confirmation of the new organisation operating model and associated governance structures. The governance that underpins the new operating model, directly impacts on the roles and responsibilities embedded within the policy as well as providing necessary operational detail (included within the appendices). **Agreed action** 1.1 Subject to confirmation of the new operating model (and governance structure) in April 2022, the audit policy will be released for Health Board wide consultation May 2022, with view to agreement through Clinical Policies and Procedures Group (CPPG) / Clinical Effectiveness Group (CEG)/ Quality, Safety & Clinical Effectiveness (QSE) by September to accommodate Cycle of Business of these groups. The reviewed policy will outline all processes and current practice in relation to clinical audit activity within BCUHB and will reinforce its role within the quality framework in delivering quality improvement and quality control and will be formally communicated to staff.	30th Sept 2022	Acting Head of Clinical Effectiveness

Matter Arising 2 – Annual Clinical Audit Plan (Operation)	**Impact**	
Tier 2 audits are those considered necessary at a corporate level because of their risk profile or requirement to improve. These audits may be undertaken within the local services or through the clinical effectiveness department; the majority are completed within the services. We note that the Clinical Effectiveness department contacts areas for their suggestions, however we have not been provided with evidence to demonstrate whether there is a review of wider information such as the Corporate Risk Register, Incidents, Never Events, patient feedback etc. to inform the plan and to ensure it is addressing risks highlighted within the Health Board. The Clinical Audit Plan for 2021/22 includes thirty-two (32) Tier 2 audits. All Tier 2 audits were given a risk assessment classification based on criteria within the spreadsheet (critical, high, medium, low), however we have not seen any further evidence of formal assessment which would explain the rationale for assigning the classification criteria to audits and justify the inclusion on the plan.	The Health Board annual Clinical Audit Plan may not reflect the significant clinical risks within the Health Board.	
Recommendation	**Priority**	
2.1 Evidence of the information reviewed to inform the plan i.e. results of previous audits, incidents, claims, review of risk registers (corporate and local) should be retained to provide assurance that the annual plan is based on risks to the Health Board. 2.2 Justification for each of the reviews included within the plan should be retained by the Clinical Effectiveness department.	High	
Agreed Management Action	**Target date**	**Responsible Officer**
2.1 – Management comment *The audit plan proforma explicitly include prompts to promote consideration of organisational risks when identifying the annual audit plan. These prompts are expanded upon and explained within the audit policy. Strong alignment between the audit plan and risks relies upon the local stakeholders being clear about their risks and reporting on their risk register. The further check*		

and challenge of the audit plan alignment to organisation risks (as required by the auditor recommendation) is dependent upon this being undertaken consistently by the areas and locality. This is an organisational action outside the scope of the Clinical Effectiveness department to solely influence. **Agreed actions** 2.1a The 2022 plan is formulated in a prescribed way with locality stakeholders identifying their key risks. We can confirm that the draft audit plan (2022/23) was checked against the current risk register by the Interim Deputy Executive Medical Director and the Interim Deputy Board Secretary as part of the corporate oversight process, changes were made to the priority of audits allocated to Tier 1, 2 as a result. This cross checking was not reflected in the current audit report. We acknowledge that the accuracy of this checking process relies upon the wider organisational risk management processes. (As described above). **[Audit note – we are advised this was underway during our fieldwork, however no evidence has been provided to corroborate this]** 2.1b In terms of immediate steps within the control of the Clinical Effectiveness team, the proforma will be strengthened to include a requirement for local stakeholders to clearly document which risks / risk sources they have considered to inform the audit selection. **2.2 – 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)	Interim Deputy Executive Medical Director/ Interim Deputy Board Secretary Acting Head of Clinical Effectiveness

• *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 Monitoring and Tracking (AMaT), this software will provide greater facility to document actions in the future.* *Once data for all required fields, mentioned above, is more readily available, when the Tier 2 projects are uploaded on to AMaT, this will improve the visibility of all projects and assist with the monitoring and tracking of the results and actions. AMaT also has the ability to be used for data collection, where appropriate. This will also enable support of monitoring and tracking through AMaT with regular (quarterly) communication with the projects leads, asking for progress using the attached proforma (may need to be reviewed/updated). AMaT structure is that the data entry fields are based on the key points of methodology that would be expected to be found in protocols for national studies. AMaT will not allow registration to proceed unless the fields are populated, therefore the services would have to provide the required information as their audits could not be registered otherwise.* *AMaT implementation was paused due to the Covid surge and redeployment of the Project Lead December 2021. The required staff capacity to progress implementation (therefore provide the required system to track and manage the additional detail required under 2.12) was included within the Clinical Effectiveness business case, submitted September 2021. Currently identified as priority 2 for funding*. **<u>Agreed Actions</u>** 2.2a Secure funding to deliver and resource AMaT implementation by submitting a new business case to support this. Whilst the business case is reviewed, appoint a temporary/fixed term project manager to support the implementation of AMaT. 2.2b Determine feasibility of augmenting the current document management system (local spreadsheet) as interim measure.	Review and submit new Business Case imminently. 30th April 2022	Acting Head of Clinical Effectiveness Acting Head of Clinical Effectiveness

Matter Arising 3 - Progress reporting (Operation)	**Impact**
The Clinical Audit Plan and the annual report have been presented at the Audit and Quality, Safety and Experience Committees, however no other reporting has been provided to these committees reflecting progress against the plan, lessons learned etc. Quarterly reports and the annual report can be seen going to the overarching Clinical Effectiveness Group from the clinical effectiveness department, although Quarter 2 and 3 reports have been issued together on the 10th February 2022 so there has been no regular reporting throughout the year, although we recognise this has been impacted by meetings being cancelled due to COVID. The reporting required is not stated within the Terms of Reference for the Group or specifically within the Cycle of Business for the meeting. *Following fieldwork we have been provided with a copy of a revised cycle of business which has been circulated for comment.* Local Clinical Effectiveness Groups are required to provide updates to the overarching Clinical Effectiveness Group, as stated in the cycle of business for the meeting. Due to the cancellation of meetings this has not been undertaken so we are unable to confirm that the overarching Clinical Effectiveness Group receives regular updates from local Clinical Effectiveness Groups.	Health Board members are not provided with assurance that the Clinical Audit Plan is progressing as expected and may be unaware of any issues in delivery of the plan. The overarching Clinical Effectiveness group is not receiving assurance from local Clinical Effectiveness Groups that audits are being undertaken / lessons are being learned.

Recommendation	**Priority**
3.1 Regular quarterly reports are to be presented to the Quality, Safety and Experience Committee, highlighting progress against the plan. 3.2 The Terms of Reference and the cycle of business for the overarching Clinical Effectiveness Group requires updating to reflect the reporting required from the Clinical Effectiveness Department and local Clinical Effectiveness Groups. This should include progress against the plan, evidence / learning and actions being taken to address lack of progress. 3.3 The overarching Clinical Effectiveness Group should receive regular reports from local Clinical Effectiveness Groups as per the Cycle of Business.	High

Agreed Management Action	**Target date**	**Responsible Officer**

Management Comment *Quarterly reports were prepared / evidence provided to the auditors. These included required updates. Presentation to Quality, Safety and Experience Committee requires the reports to first be presented to Clinical Effectiveness Group, however meetings were stood down during COVID.* **Agreed actions** 3.1 The quarterly reports will be added to the first available Quality, Safety and Experience Committee which will be May 2022 (following presentation at Clinical Effectiveness meeting, which will be April 2022). 3.2 and 3.3 The Cycle of Business will be strengthened for both Clinical Effectiveness Group and Quality, Safety and Experience Committee to be explicit about the reports delivered. Quarter 2 and 3 reports will be included in updated cycle of business / recognising the 10th February Clinical Effectiveness Group was not quorate, the Cycle of Business (CoB) developed will require formal sign off. It will be requested for the May Quality, Safety and Experience Committee to sign off an amended Clinical Effectiveness Group Terms of Reference and Cycle of Business, and also request the Quality and Safety and Experience Committee Cycle of Business is amended to reflect quarterly reports.	31st May 2022 30th April 2022 31st May 2022	Acting Head of Clinical Effectiveness Acting Head of Clinical Effectiveness Acting Head of Clinical Effectiveness

Matter Arising 4 – Feedback and learning from Clinical Audit reports (Design and Operation)	**Impact**
Tier 1 Welsh Government national mandated projects are expected to complete a two stage proforma (Part A, B). The proforma includes the improvement plans and any progress between data collection and reporting. For the year 2020/21 out of 26 audits 13 (50%) of part A were returned within the deadline; 10 (39%) returned after the deadline with 3 (11%) not being returned. We are aware that exception reports have started being produced however we are not able to see the impact of this process yet.	Feedback on national audits is not being provided to Welsh Government within the deadlines required. Lessons learned from clinical audits are not shared with the overarching

We note the methodology to measure compliance for Tier 1 audits is one that could favour a positive outcome and may provide false assurance on compliance if this is not measured by site. Whist an overall score may be required for reporting to Welsh Government we would suggest that the site scores be reported within the Health Board to enable issues / lack of compliance at sites to be reported and addressed. Feedback provided to the Quality, Safety and Experience Committee and Clinical Effectiveness Group meetings focused on progress and completed actions. We are unable to evidence feedback on issues raised or learning from the results of the audits, and how these are being shared across the Health Board. We note that the Clinical Effectiveness Department have recently introduced Health Check meetings with divisions to receive feedback and results of audits.	Clinical Effectiveness Group to allow sharing across the Health Board.

Recommendation	**Priority**
4.1 The return of proforma A and B requires immediate improvement. We note that actions are underway to address this via regular Health Check meetings. Regular exception reports should be provided to the local East and Central Clinical Effectiveness Groups and the West Quality, Safety and Clinical Effectiveness Group Meeting. 4.2 Compliance on Tier 1 audits should be reported by site within the Health Board to ensure that the methodology used does not provide overly positive assurance on compliance. 4.3 Feedback and lessons learned from audits should be included within reporting to Groups and Committees to provide assurance to the Health Board and ensure communication across sites / divisions.	High

Agreed Management Action	**Target date**	**Responsible Officer**
<u>Management Comment</u> *National timescales stood down at height of COVID and reports were no longer required for submitting to Welsh Government. In 2021 / February 2022 we have additionally had clear direction from organisation to prioritise front line service delivery and step down non-essential activity. Audit*		

was one of these areas which was paused or reduced as part of this. The underlying reason for non-compliance (as reflected on our risk register) within responses from Clinical Leads was identified as insufficient capacity within the corporate team and localities (this deficit was exaggerated by COVID) but some capacity deficit predated it. The Clinical Effectiveness business case was submitted to address the underlying cause. The business case has been given priority 2 within the Integrated Medium Term Plan (IMTP) process, at the moment, there are discussions for the next date to resubmit for next year, but nothing has been finalised yet. *The AMaT license has been renewed for two years accounted for within 2021/2022 financial year with savings made for extended the license for two years. This will enable funding allocated against AMaT in 2022/2023 and 2023/2024 financial years to support funding of temporary staff. Structured assessment will take place over the next two years to clearly quantify the benefits realisation of AMaT, which will inform the decision to renew the license which is due for renewal 1st April 2024* *Also with regard to the reference above to site scores and compliance, just to confirm the level the data is reported at is determined by the host of the national audit and not by all those that report data for BCUHB at a site level.* **Agreed Actions**		
4.1a Using temporary/fixed term staff to support the team initially, also finalise discussions with Quality department and consider secondment options will enable us to review resources needed. Following on from this, the business case will be reviewed, as we will have a clear overview of the gaps in the service to base final details on	31st October 2022	Acting Head of Clinical Effectiveness
4.1b Ensure that health check meetings are continued, to secure understanding and engagement / accountability of triumvirates, whilst other changes are in place to ensure consistency.	31st May 2022	Acting Head of Clinical Effectiveness
4.2 We can confirm that monthly exception reports are already provided to the localities with regard to Tier 1 mandatory audits (evidence has been provided to the audit team). These are sent to locality Clinical Effectiveness Groups/ equivalent. Locality issues are included	30th September 2022	Acting Head of Clinical Effectiveness

within quarterly reports noting which audit, issues relating and escalated the named leads, any gaps with responses and any participation issues. Moving forward we will ensure this work continues and is minuted.		
4.3 a) Revisit locality reporting, specifically review format of report (including metrics) and map where currently reports are distributed. Use this opportunity to align proposed reporting approach (format of the report and where circulated and for what purpose) to new operating model for governance. Submit proposal to Clinical Effectiveness Group, once approved update cycle of business of receiving groups appropriately.	30th September 2022	Acting Head of Clinical Effectiveness
b) Fully implement clinical review of audit results (as per drafted process developed February 2022) within the corporate clinical effectiveness team, sufficient to inform the teams early identification, reporting and escalation of locality and BCU audit related clinical risk and learning, as part of the corporate teams reporting and assurance function. This will provide greater focus on the output of clinical audit, which can then be integrated into the locality reports. NB – this requires the clinical capacity which is reflected in the business case.	Contingent with review of Business Case to ensuring clinical capacity included	Acting Head of Clinical Effectiveness and OMD Medical Director
c) Secure capacity identified within business case (delivering a hub and spoke model to increase capacity within central team aligned to locality. d) Discussions have been had with Associate Director of Quality to establish synergies between Quality and Clinical Effectiveness and whether there is capacity within the team to support us. Further discussions will be followed up. e) Ensure continuation of current health check meetings to develop and maintain division visibility of audit activity and risks, and to promote engagement and accountability.	c), d) & e) 31st May 2022	Acting Head of Clinical Effectiveness and OMD Medical Director/Acting Associate Director of Quality

Matter Arising 5- Tier 3 audits (Design and Operation)	**Impact**
A self-registration database holds the details of all Tier 3 audits that have been registered by divisions / localities. We are not aware that this list of audits is shared wider i.e. with divisions, to avoid duplication of audits / resources. Tier 3 audits are considered closed when the audit report has been uploaded. There is no evidence that these reports / findings are shared wider across the Health Board. There is no oversight of the Tier 3 audits being undertaken across the Health Board and progress is not reviewed centrally or included in the reporting to QSE. We were informed that due to the lack of resources with the clinical effectiveness department, management of the Tier 3 audits is being managed through the divisions / localities. A review of the data held within the clinical audit self-registration database (April -December 2021) identified the following:31 of 113 had either N/A or was left blank in the please select any other reasons why the audit is required. This means there are 31 audits had no reasoning given for undertaking the audits. • 278 Tier 3 audits had been registered since the 1st April 2021. • 232 audits (83%) were ongoing at the time of review. • 113 (41%) of the audits had "other" as the main reason why the project is required, this is a drop-down section when completing the self-registration. Thirty-one (27%) of the 113 had either N/A or no comment in the reason why the audit is required. This means there are 31 audits registered that have no reasoning or justification for undertaking the audits. According to the policy all Tier 3 audits should be risk based. We have been unable to evidence any description of risks/risk assessment justifying the registration audits.	Tier 3 audits do not have appropriate assessments in place to justify the audit, which could result in clinical resource being utilised for an audit which may not have any benefit for the Health Board.

Recommendation	Priority	
5.1 Reasons why Tier 3 audits are required should be reviewed to ensure there is justification in at least one of the two sections that require a reason. The uploading of an assessment for each audit would further strengthen the reason/justification for undertaking the audit. 5.2 The list of Tier 3 audits should be shared with divisions / localities to ensure there is no duplication of audits / efforts across the Health Board. This would also provide opportunities for work across more than one division / locality. 5.3 Results and lessons from Tier 3 audits should be shared across the Health Board. Noting that divisions / localities are responsible for Tier 3 audits, we would suggest the learning / feedback is provided to the Clinical Effectiveness Team and a process put in place to ensure this learning / feedback is shared across the Health Board.	High	
Agreed Management Action	**Target date**	**Responsible Officer**
5.1 A meeting has been held on 6th April 2022 with a Senior Development Analyst within Informatics, to review the web application/database and develop additional prompts within the registration process to provide more assurance with regard to background behind reasons for undertaking the audit, lessons learnt, sharing of updates across BCUHB.	30th June 2022	Senior Development Analyst
5.2 The Clinical Effectiveness team will continue to make monthly and quarterly checks to ensure no duplication of audits happens, and will start sharing updates on the Clinical Effectiveness webpage in Quarter 1.	30th April 2022	Clinical Effectiveness Team
5.3 a) Rollout of AMaT for Tier 1 and Tier 2 and NICE guidance will take place in the first instance and dependant on the implementation of the software across BCUHB, Tier 3 will be rolled out at a later date. This will include capturing outcomes from audits.	31st December 2022	Acting Head of Clinical Effectiveness with support of team
b) By developing the Tier 3 self-registration further to incorporate the prompts noted in the recommendations, this will allow assurance of the current process, whilst allowing time to rollout Tier 3 on AMaT at a later date. Resource has been identified as required within business case and submitted per IMTP process, currently priority 2, however not approved, new date has not been given to resubmit.	31st March 2023	

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Nursing Roster Management: Introduction of e-timesheets for Agency staff

Final Internal Audit Report

May 2022

Betsi Cadwaladr University Health Board

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

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Contents

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Fieldwork completion:	14 April 2022
Discussion Draft report issued:	25 April 2022
Draft report issued:	4 May 2022
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Final report issued:	25 May 2022
Auditors:	Principal Auditor, Deputy Head of Internal Audit
Executive sign-off:	Executive Director Workforce & Organisational Development
Distribution:	Executive Director of Finance, Director of Nursing, Deputy Director - Operational Workforce, Associate Director Workforce Planning & Performance, Head of Resourcing, Manager - Temporary Staffing, Interim Board Secretary, Statutory Compliance, Governance & Policy Manager
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The objective of the audit was to assess the implementation and effectiveness of the new arrangements for agency e-timesheets.

Overview

We have issued limited assurance in this area. The significant matters which require management attention include:

- The majority of agency staff timesheets are not being submitted by agencies within 48 hours, as required in order to allow time to be reviewed for accuracy prior to payment.
- Shifts of over 12 hours require a one-hour break. Where a shorter break is entered by an agency this should be amended to one hour. This has not been applied within the Health Roster Bank Staff system to a number of shifts of 12 hours or more, which is resulting in incorrect pay/overpayments to agencies and increased costs to the Health Board.
- Regular reports detailing shift changes are required to be sent to Heads of Nursing for monitoring on weekly basis. These are not being sent regularly and are providing all shift details, not just changes, resulting in shift changes not being reviewed.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	There is a policy and procedure in place that outlines the process to be followed to submitting and approving timesheets for agency staff.	Reasonable
2	Staff who are responsible for reviewing and signing off agency timesheets have been provided with appropriate guidance and support for the implementation of the changes with training available as required.	Substantial
3	Agency timesheets have been reviewed and signed off by an appropriate person in a timely manner.	Reasonable
4	Where there are changes to the shift worked, i.e. hours worked are in excess or breaks have been amended, reasons for these changes are captured on the system	Limited
5	There is regular monitoring of compliance with policy / procedure requirements	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	The Health Board Rostering Policy is overdue for review and the standard operating procedure for Agency Timesheets needs to be approved and activated.	1	Operation	Medium
2	A high percentage of timesheets are not submitted by agencies within 48 hours, limiting the time for these be checked for accuracy prior to payment.	3	Operation	High
3	One hour break implementation is not being applied within the Health Roster Bank Staff system for a number of shifts of 12 hours or more. This has resulted in agency staff being paid extra, resulting in a cost for the Health Board.	4	Operation	High
5	Weekly reports with accurate data on shift changes are not being provided to Heads of Nursing on a regular basis, as required by the standard operating procedure.	5	Operation	High

1. Introduction

1.1 The review of Nursing Roster Management: Introduction of e-timesheets for Agency staff has been completed in line with the 2021/22 Internal Audit Plan. The review sought to provide assurance to Betsi Cadwaladr University Health Board (the 'Health Board') with assurance that there are effective processes in place to implement electronic timesheets for agency staff.

To meet demand placed upon the Health Board's services, the Health Board is required to make arrangements to manage the deployment of its workforce efficiently and effectively. In doing so it must continue to deliver care which is of the highest quality to its service users.

Rostering is fundamental to ensuring that staff are deployed in the most efficient way to ensure the best use of public money in the delivery of NHS services and that the needs of the patient are placed firmly at the centre of the management of the workforce.

The Health Board currently has more than 1,000 Nursing Agency workers filling over 19,171 shifts across all nurse staffing in the last 6 months.

Workforce & OD developed standard operating procedure (SOP) to support the move from paper timesheets to electronic timesheets for Agency staff. This aims to reduce the carbon footprint by reducing paper usage, giving ownership of shifts worked to supplying agencies, allowing them to amend shift times prior to approval, and improve accuracy of payments to agencies.

This has been in place since October 2021, with the Temporary Staffing Team providing advice, guidance and reviewing the data on agency shifts.

1.2 The following risks were identified at the outset of the review:

- agency shifts are not reviewed and signed off promptly, resulting in delayed payments and breach of the All-Wales Agency Contract agreement; and
- exceptions approved on the system do not correspond with ward records, resulting in additional costs for the Health Board.

1.3 The scope was limited to the following areas:

- there is a policy and procedure in place that outlines the process to be followed to submitting and approving timesheets for agency staff;
- staff who are responsible for reviewing and signing off agency timesheets have been provided with appropriate, guidance and support for the implementation of the changes with training available as required;
- agency timesheets have been reviewed and signed off by an appropriate person in a timely manner;

- Where there are changes to the shift worked, i.e. hours worked are in excess or breaks have been amended, reasons for these changes are captured on the system, reconcile to ward exception sheets, and have been signed off by an appropriate person; and
- there is regular monitoring of compliance with policy / procedure requirements i.e. time to lock down rosters / required breaks / exception reporting.

2. Detailed Audit Findings

Objective 1: There is a policy and procedure in place that outlines the process to be followed to submitting and approving timesheets for agency staff.

2.1 There is a Health Board Rostering Policy (WP28a) which can be found on the Health Board intranet and was approved in December 2014. The policy was due for review in 2019. We are advised that there is work ongoing at an All-Wales level which will impact on local policies.

2.2 There is no reference within the policy that outlines the process for submitting and approving E-timesheets for agency staff, although we do note that the introduction of agency E-timesheet is a new process which has been trialed from the 18th October 2021 to the 31st December 2021.

2.3 We were provided with a draft standard operating procedure (SOP) for temporary staffing E-timesheets for agencies which has been subject to update following recommendations from Counter Fraud. The SOP outlines the process to be followed and contains instructions on how to add and amend timesheets in the rostering system. The SOP has not been formally approved or published as feedback / learning from the trial will be incorporated prior to final approval.

Conclusion:

2.4 There is a Health Board Rostering Policy in place however this is overdue for review (although we do note that this will be impacted by work being undertaken at an All-Wales level). Reference to the E-timesheets and the corresponding SOP should be included within the policy. The draft SOP for E-timesheets also needs to be approved and published. We have concluded **reasonable assurance** for this objective.

Objective 2: Staff who are responsible for reviewing and signing off agency timesheets have been provided with appropriate, guidance and support for the implementation of the changes with training available as required.

2.5 The SOP provided states the following within section three:-

'Training and Support

Temporary Staffing Team will provide advice to All HON/Matrons and HON's as well as all Agencies, to ensure correct process is followed.

Temporary Staffing Team will run live demonstrations prior to go live date with All Agencies.'

2.6 We were provided with two presentations, one for the Health Board and the other for Agencies, outlining the reasons for change and the process to be followed. We received evidence of two live demonstrations which took place on the 7th October 2021 and the 11th October 2021. Training registers were also provided which included both agency staff and Health Board staff (Workforce & Organisational Development).

2.7 We were provided with other evidence to support communication with relevant Health Board staff, including ward staff, and agencies to advise them on the new process, including:-

- A guidance document on how to add a timesheet,
- Email communication reminder to ward managers on the beginning of the trail for agency E-Timesheets,
- Agency E-Timesheet's flowchart highlighting the process,
- Guidance for the temporary staffing team on how to run weekly agency timesheet exception reports for any shift time changes, and
- E- Rostering amendments form which denotes any shift time changes.

2.8 The Temporary Staffing team are available for any advice or queries that is required on the system, with a generic email address for general enquiries.

Conclusion:

2.9 Guidance has been provided to the relevant staff within the Health Board and agencies. This has been through training, presentations, guidance documents and e-mail communications. The Temporary Staffing team also provide advice and help as required for both the Health Board staff and Agency staff. We have concluded **substantial assurance** for this objective.

Objective 3: Agency timesheets have been reviewed and signed off by an appropriate person in a timely manner

2.10 All shifts are detailed within the E-Rostering system. Within the system there is an audit trail function which allows staff to track any changes to shifts and includes the time the changes were made and signatures of who made them.

2.11 The SOP provided states the following:

'In order to set-up the E-Timesheets, the following process needs to be followed:

Agencies to be asked to submit timesheets via booking system within 48hrs following a shift to avoid any pay discrepancies' and to give the roster managers time to check accuracy prior to locking for pay.'

2.12 We exported a sample of submitted timesheets from the Health Roster Bank Staff system for the week of 13th – 19th March 2022. A total of 652 agency shifts had been submitted. Of these:

- 311 (48%) were submitted within 48 hours, as per the policy.

- 341 (52%) were not submitted within 48 hours. Of the 341, 54 (16%) were submitted seven days or over following the completion of the shift.

2.13 The Standard Operating Procedures states *'Agency shifts are to be locked in a timely manner'*. Of the 652 agency shifts:

- 645 were locked within 3 days.
- 7 shifts were locked over 3 days from the agency inputting the details to the ward manager/appropriate person signing off the shift.

Conclusion:

2.14 Over half of the timesheets reviewed for one week were not submitted by agencies within 48 hours following a shift. This may not provide roster managers with sufficient time to check the accuracy of and approve these shifts, which may impact on the payment to the agencies. However, for the sample of shifts we reviewed, these had been signed off by Health Board staff in a timely manner. Therefore, we have concluded **reasonable assurance** for this objective.

Objective 4: Where there are changes to the shift worked, i.e. hours worked are in excess or breaks have been amended, reasons for these changes are captured on the system

2.15 Shifts worked by Agency staff are booked in the Health Roster Bank Staff system. Following completion of the shift, the agency staff member will complete a timesheet and provide this to the agency. The agency will then log into the system and add the actual hours worked. Any difference between the booked hours and actual hours worked are logged at this point. Reasons for any changes are also recorded in the system via a drop-down list. The agency then save changes and agrees a disclaimer for the time changes.

2.16 Prior to the roster managers locking down the hours worked, the hours will be checked against an exception sheet which is kept on the wards. These are completed by agency staff to detail any changes in hours worked and the reasons why.

2.17 We were provided with a spreadsheet of all agency shifts undertaken and finalised for a 15-week period (18th October 2021– 26th January 2022). The spreadsheet was exported form the Health Roster Bank Staff system. From a total of 9,533 agency shifts finalised, 194 shifts with a change in hours were identified. All but one had stated a reason for the change in shift times from the drop-down section.

2.18 The SOP provided states:

'Appendix A Agency Add Timesheet Guide

Please be advised due to the 1 hr break implementation (19th June 2019) for any shifts of 12hr's or more, if Break times are changed to less than 1hr then the temporary staffing team will amend the break as per our process to 1hr.'

2.19 From the of the 9,533 shifts, 482 (5%) of agency shifts where the staff had worked 12 hours or more had breaks recorded that were under one hour. These should

have been amended to one hour on the system, as per the policy.

2.20 We were not able to establish from the system if a reason had been given for not implementing the one-hour process.

2.21 As the breaks were not changed, this has resulted in agency staff being paid extra.

- Total actual break time taken for the 482 agency shifts = 11,835 minutes.
- Total break time that would have been taken had the 1-hour process been applied = 28,920 minutes.
- 28,920 – 11,835 = 17,085 minutes (284.75 hours)

Using the findings above we calculated the cost of the break not being applied using the rate of a mid-point band 5 agency nurse.

- Basic rates 285 hours x £30.30 = £8,635
- Nights & Saturday 285 hours £39.39 = £11,226

2.22 We also exported the submitted timesheets for the week of 13th March – 19th March 2022. We found that 652 agency shifts had been submitted, of which 39 staff had worked 12 hours or more without the one-hour process being applied.

We reviewed the paper timesheets that are held with agencies for ten shifts and found that five of the agency staff had recorded one hour on the paper timesheet however 30 mins had been entered on the Health Roster Bank Staff system. Whilst one staff member had indicated no break on the paper timesheet however 30 mins was input onto the system.

Conclusion:

2.23 One hour break implementation is not being applied within the Health Roster Bank Staff system to a number of shifts that have worked 12 hours or more, resulting in a cost deficit for the Health Board. From our sample of ten timesheets the breaks input by agencies for six of these (60%) were inaccurate, and result in agency staff being paid additional time.

2.24 From the testing undertaken, assuming the same error rate across the year, the Health Board could be over-charged by approximately £32,000 per year, based on basic rates and does not include night/Saturday rates. Consequently, we have concluded **limited assurance** for this objective.

Objective 5: There is regular monitoring of compliance with policy / procedure requirements

2.25 The Rostering Policy does not reflect the changes to the new Health Roster Bank Staff system. The draft standard operating procedure (SOP) has been developed to establish the procedure requirements, and states:

'The temporary Staffing team will run a report weekly on all changes and as such, all changes will be sent onto the heads of Nursing for their information.'

2.26 Agency E-timesheets were introduced on the 18th October 2021, we have received weekly reports for the heads of Nursing for the following weeks.

- 27th February 2022 – 5th March 2022
- 6th March 2022 – 12th March 2022

We were informed that there had been no other reports sent at the time of fieldwork.

2.27 The intention of the weekly reports is to highlight any changes to the shifts agreed i.e. following input by the agency to reflect actual times worked. The two weekly reports included both times that had been changed and times that were the same as the rostered hours (times that had not been changed). It appears that reports are exported from the Health Roster Bank Staff system based on the reasons input by the agencies, rather than where there are actual changes in shift.

Due to the reasons section within the system not being used appropriately (i.e. it is being used when the shift has not changed), the report is not providing Heads of Nursing (HON) with an accurate list of exceptions.

Conclusion:

2.28 WP28a requires the inclusion of agency E-Timesheets for compliance. Regular reports are required to be sent to HONs for monitoring every Monday which include only the time changes made by the agency.

2.29 The reasons section within the system (inputted by agencies) are currently being completed inaccurately which in turn effects the reporting to the HONs. Consequently, we have concluded **limited assurance** for this objective.

Additional testing

2.30 Following internal audit input into the agency self-billing processes at an All-Wales level, we were advised to consider the controls in place at Health Boards to ensure information provided to payroll is accurate. We considered the process for the extraction of data from the roster system to payroll, the process for entering agency pay rates into the system and ensuring shifts matched the payment file and were paid the correct rate. The details below are included for information and are not considered as part of the overall assurance opinion.

2.31 **Process for sending shift details to Payroll for payment**

A payment report is sent on a payroll run every Monday, Wednesday and Friday by the Temporary Staffing team. Payroll then process the payments, and the agency then receive invoices with details of payments.

2.32 **Accuracy of payment files**

We were provided with a payment report for the 6th April 2022 which had been extracted from the roster system. Hours shown on the payment file were compared against hours on the system. We sampled 35 of the 542 agency shifts and all hours on the payment file matched hours on the roster system.

2.33 **Correct agency rate is applied** Agency rates are input to the roster system by the Roster Management Team using the contract schedule for agency nurses (1st March 2021 – 28th February 2025). We agreed agency hourly rates taken from an agency pay rates spreadsheet which had been provided to us, against the payment file containing a total of 542 agency shifts to ensure the correct hourly rate is being applied. We reviewed:

- five on contract agencies totalling 178 shifts both basic and specialist rates - all five agencies had received the correct hourly rate.
- two off contract agencies were sampled totalling 171 shifts both basic and specialists rates - all rates were correct.
- Agency HCA rate totalling 28 basic and specialists rate - all received the correct hourly rate.

2.34 We were informed of issues where agency staff on enhanced rates who have been used to fill shifts in specialist areas are being moved to work in general wards due to staff shortages. This would indicate that some of the general wards are not filling shifts as required, resulting in the Health Board paying the enhanced rates to agency staff undertaking these shifts.

Conclusion

2.35 This testing has been included for information only and has not been given an assurance rating or considered as part of the overall rating for the review.

Appendix A: Management Action Plan

Matter Arising 1: Policies and Procedures (Operation)		**Impact**
WP28a Rostering Policy is available on the Health Board intranet site and was approved in December 2014, with a review due in December 2019. Presently there is no reference within the policy that outlines the process for submitting and approving E-timesheets for agency staff. We were provided with a draft standard operating procedure (SOP) for temporary staffing E-timesheets for agencies.		Policy will not be reflective of current practice due to the addition of Introduction of e-timesheets for Agency staff. Lack of understanding on how to complete E-timesheets.
Recommendations		**Priority**
1.1 Policy WP28a requires a review, needs to include a reference to the E-timesheets also include the SOP within the documents to be read alongside the policy section on the first page. 1.2 Draft SOP needs to be approved and activated.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Policy WP28a has been reviewed and is with Workforce Policy Group for consideration. Policy to be approved and deployed with a clear compliance audit schedule in place and commenced.	31st July 2022	Associate Director Workforce Planning & Performance
1.2 Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team.	31st July 2022	Associate Director Workforce Planning & Performance & Director of Nursing for Workforce,

1.3	Interim SOP (with exception of paid break element) to be approved for a 3 month period to ensure clarity of process and accountability in intervening period.	30th June 2022	Staffing and Professional Standards Associate Director Workforce Planning & Performance

Matter Arising 3: Submission of timesheets by agencies (Operation)	**Impact**
The SOP provided states '*Agencies to be asked to submit timesheets via booking system within 48hrs following a shift to avoid any pay discrepancies' and to give the roster managers time to check accuracy prior to locking for pay'.* We exported a sample of submitted timesheets from the Health Roster Bank Staff system for the week of 13th – 19th March 2022. A total of 652 agency shifts had been submitted. Of these: • 311 (48%) were submitted within 48 hours, as per the policy. • 341 (52%) were not submitted within 48 hours. Of the 341, 54 (16%) were submitted seven days or over following the completion of the shift.	Potential for pay discrepancies due to lack of time to check accuracy of agency shifts

Recommendations	**Priority**
2.1 Agencies are formally reminded of the requirement to submit timesheets within 48 hours to ensure roster managers have sufficient time to check these. Compliance with the submission of timesheets to be monitored and where there are continued delays this should be escalated via contract arrangements.	High

Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Formal letter to be issued to all agencies from Executive Director of Workforce & Organisational Development.	31st May 2022	Associate Director Workforce Planning & Performance
2.2 Communication to be sent to all Heads of Nursing, Matrons and Ward Managers to emphasise requirement to lock down and record variations to working hours.	31st May 2022	Associate Director Workforce Planning & Performance

2.3 Training sessions to be held again with Heads of Nursing, Matrons and Ward Managers to ensure understanding of requirements.	30th June 2022	Associate Director Workforce Planning & Performance & Director of Nursing for Workforce, Staffing and Professional Standards

Matter arising 3: Implementation of 1 hour breaks (Operation)	**Impact**
The standard operating procedure for Agency timesheets states '*Please be advised due to the 1 hr break implementation (19th June 2019) for any shifts of 12hr 's or more, if Break times are changed to less than 1hr then the temporary staffing team will amend the break as per our process to 1hr'* The one-hour break implementation is not being applied to a number of shifts of 12 hours or more within the Health Roster Bank Staff system, resulting in a cost deficit for the Health Board. From 18th October 2021– 26th January 2022 (15 weeks), we found a total of 482 out 9533 agency shifts where the agency staff member had worked 12 hours or more, but the break had not been amended to one hour. We exported the submitted timesheets for the week of 13th March – 19th March 2022. We found that 652 agency shifts had been submitted of which 39 staff had worked 12 hours or more without the 1-hour process being applied. Ten of these shifts were compared against paper timesheets which are held with the agency companies. Five of the agency staff had recorded 1 hour on the paper timesheet however 30 mins had been entered on the Health Roster Bank Staff system. Whilst one staff member had indicated no break on the paper timesheet however 30 mins was input onto the system.	Pay discrepancies leading to over payments to agencies.
Recommendations	**Priority**
3.1 The Temporary Staffing Team to regularly review 12 hour shifts on the system (prior to submission to payroll) and amend the break times as per the procedures. 3.2 Agencies are formally reminded of the requirement to input breaks according to the timesheets submitted, and reminded of the declaration included on the system where they are confirming the details entered are correct.	High

3.3 Roster managers to be formally reminded of the requirement to check shifts match timesheets / exception sheets before they are locked for payment. 3.4 The 12 hour shifts where the break has not been adjusted should be identified and steps taken to recover the overpayments. 3.5 The Temporary Staffing team should regularly check a sample of shifts on the system against paper timesheets retained by agencies.		
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 (as per 1.2) Draft SOP to be reviewed to amend reference to unpaid break to acknowledge the risks associated on safe staffing in conjunction with Corporate Nursing Team.	31st July 2022	Associate Director Workforce Planning & Performance & Director of Nursing for Workforce, Staffing and Professional Standards
3.2 Revised SOP to be clear on responsibility within Nursing for amending working hours in line with Safe Care	31st July 2022	As above
3.3 Revised SOP approved by People & Culture Executive Delivery Group and implemented	31st August 2022	As above

Matter Arising 4: Weekly exception reports (Operation)		**Impact**
Regular weekly exception reports are not being provided to the Heads of Nursing in line with the standard operating procedure, which states '*the temporary Staffing team will run a report weekly on all changes and as such, all changes will be sent onto the heads of Nursing for their information.'* We were provided with two examples of weekly reports which included both times that had been changed and times that were the same as the rostered hours (times that had not been changed). It appears that reports are exported from the Health Roster Bank Staff system based on the reasons inputted by the agencies. Due to the mistaken use of the reasons section within the system this is not giving a true reflection of how many weekly changes there have been.		Heads of Nursing are not provided with the correct information for review on a regular basis.
Recommendations		**Priority**
4.1 Weekly reports detailing shift changes to be sent to all Heads of Nursing in accordance with the SOP 4.2 Agencies are formally reminded of the use of the 'reasons' section within the system so that there is an accurate representation of any changes made when exporting weekly reports from the system.		High
Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 Roster Performance Compliance Reports (including agency worker working hours) to be circulated to Heads of Nursing on a minimum of a monthly basis (higher frequencies agreed with Corporate Nursing based on compliance performance).	30th June 2022	Associate Director Workforce Planning & Performance & Director of Nursing for Workforce, Staffing and Professional Standards

4.2 Compliance with Roster Management Policy (and SOP) to be included in Monthly Workforce Performance Reports considered by senior management teams	30th June 2022	Associate Director Workforce Planning & Performance

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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On-call arrangements
Final Internal Audit Report

June 2022

Betsi Cadwaladr University Health Board

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

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

Contents

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Report status:	Final Internal Audit Report
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Fieldwork completion:	26 April 2022
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Final report issued:	6 June 2022
Auditors:	Deputy Head of Internal Audit, Head of Internal Audit
Executive sign-off:	Interim Director of Regional Delivery, on behalf of the Deputy Chief Executive
Distribution:	Associate Director Workforce & OD Interim Director of Regional Delivery Head of Tactical Control Centre Emergency Preparedness Resilience and Response Lead
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The purpose of this audit was to provide the Health Board with assurance that on-call arrangements are effective, with processes in place to ensure staff receive the relevant payments and compensatory rest periods.

Overview

The significant matters which require management attention include:

- On-call arrangements have not been reviewed for a number of years. Several staff have raised the issue of on-call arrangements being unsafe, impacting patients, and have been awaiting the outcome of promised reviews.
- The ratio and skill mix for rotas is not documented and there appears to be inequity as to who is included on some rotas.
- Guidance on compensatory rest is included in Health Board policies, however these are all overdue for review. Half of staff who responded to our questionnaire were unaware of the guidance and the majority do not have the capacity to take compensatory rest.
- There is little training/guidance in place for those on call to familiarise themselves/refer to concerning responsibilities whilst on call/crib sheets for sites/services that they are unfamiliar with.

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1.	On-call arrangements across the Health Board	Limited
2.	Rota compilation and sustainability	Limited
3.	Compensatory rest periods	Limited
4.	On-call payment arrangements	Substantial
5.	Training	Limited

1 The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion.

Key Matters Arising		Assurance objective	Control Design or Operation	Recommendation Priority
1	On-call arrangements, including guidance have not been reviewed for a number of years, with concerns raised by staff on the sustainability and impact of the pressure on staff wellbeing.	1	Design	High
2	The skill mix and ratio for rotas is not documented, and changes in staff will impact on the sustainability of rotas.	2	Design	High
3	All staff are not aware of the requirements to take compensatory rest (where applicable), and the	3	Operation	High

	Key Matters Arising	Assurance objective	Control Design or Operation	Recommendation Priority
	majority do not take it due to work commitments.			
4	There is little guidance available for staff on-call outlining what is expected or providing information on key sites / services that staff may not be familiar with.	5	Design	High

1. Introduction

1.1 This review has been completed in line with the 2021/22 Internal Audit Plan. The review has sought to provide the Health Board with assurance that on-call arrangements are effective, with processes in place to ensure staff receive the relevant payments and compensatory rest periods.

1.2 On-call systems are in place to provide appropriate service cover across the Health Board. Staff are on-call when they are available outside of their normal working hours – either at the workplace, home or elsewhere – to work as and when required. New on-call arrangements in Wales were agreed in 2012, with principles and implementation guidance set out in a Welsh Government Pay Letter (AfC(W)3/2012).

1.3 The overall objective of the audit was to review the robustness of on-call arrangements across the Health Board and compliance with the principles set out in the Pay Letter above. The scope of the review included the following:

- a review of on-call arrangements in place across the Health Board;
- rotas for on-call include the relevant mix / seniority of staff and are sustainable;
- monitoring and recording arrangements for compensatory rest periods following on-call duty;
- on-call payment arrangements are applied fairly across the Health Board; and
- there is training in place for staff.

1.4 The potential risks considered at the outset of the review were:

- on-call arrangements do not meet the needs of the Health Board and do not comply with the Welsh Government Pay Letter;
- rotas are not robust and sustainable, resulting in over-reliance on some members of staff; and
- staff are not paid for on-call duties or do not take compensatory rest periods.

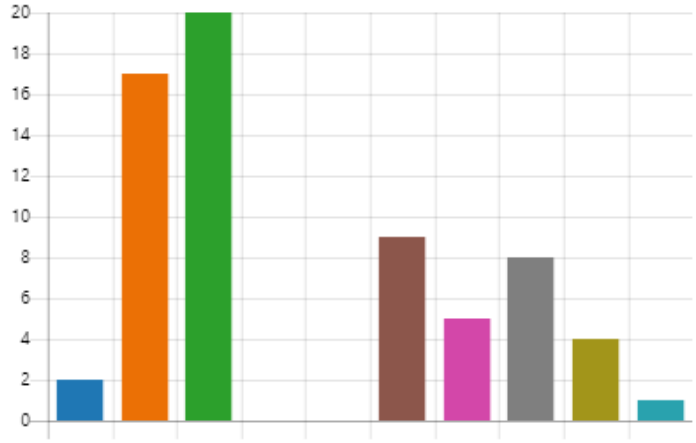
1.5 The scope of the audit has considered 'business as usual' on-call arrangements and has not reviewed the arrangements in place for Emergency Preparedness Resilience and Response.

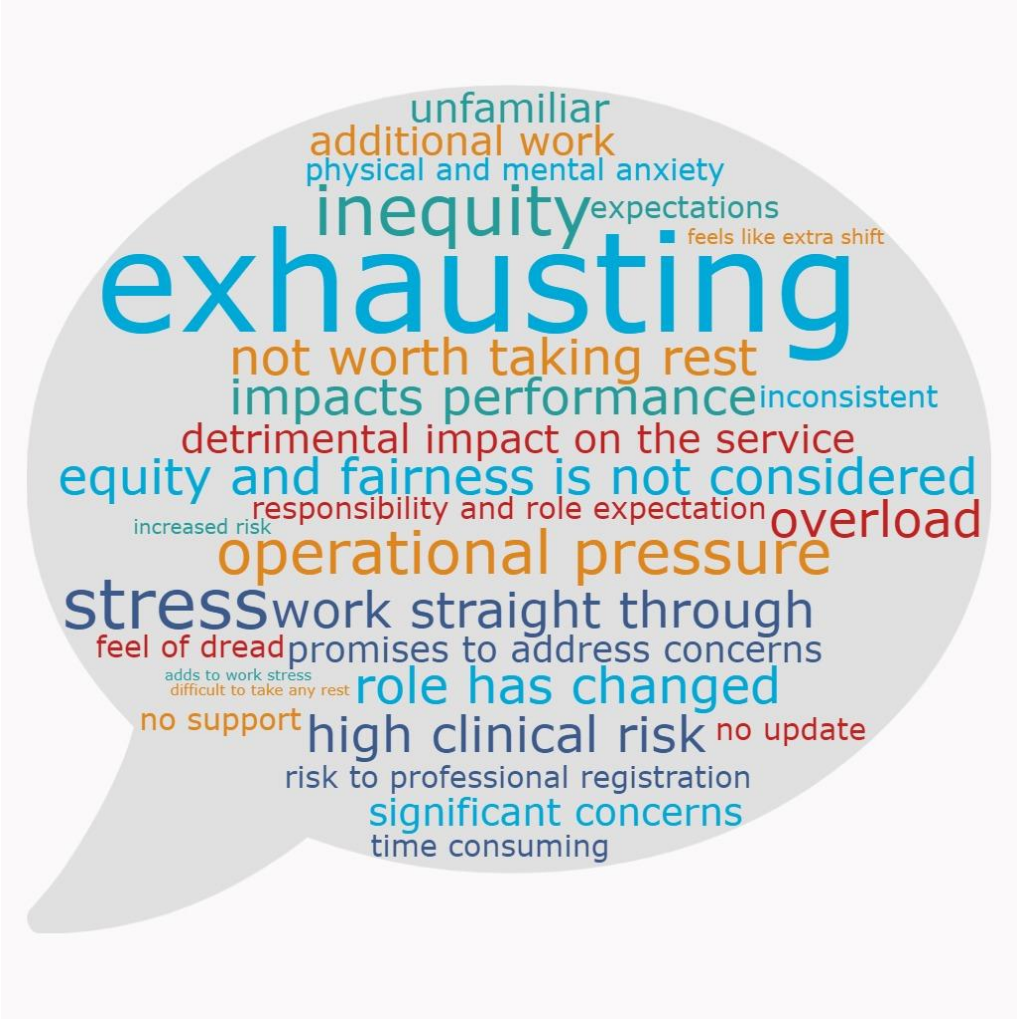
2. Detailed Audit Findings

2.1 A key part of fieldwork for this audit was canvassing opinions from staff on how arrangements work for different rotas. A questionnaire was issued to 148 staff included in various on-call rotas across the Health Board, as of October 2021. A total of 62 staff responded to our questionnaire as at the end of February 2022 – the mix of the responses by rota is shown below (please note that staff may be included in more than one rota).

Key comments from the questionnaire have been included in the diagram below and relevant objectives, with detailed comments from staff included in Appendix B.

Gold on-call	2
Silver on-call	17
Bronze on-call	20
System Lead	0
MHLD Silver	0
MHLD Bronze	9
Womens	5
Matron of the Day	8
Community	4
Other	1





Objective 1: On-call arrangements across the Health Board

2.2 There are a number of on-call rotas covering services across the Health Board. We have reviewed the Gold, Silver and Bronze level of rotas which cover the Health Board sites 24 hours a day, 7 days a week. These are detailed in table 1 below.

Table 1: On-call rota coverage

On-call rota	Coverage
Gold (out of hours)	Covers out of hours operation. Rota is made up of Executives / Directors. Gold on-call are an escalation route for silver on-call and issues that require executive input.
Silver on-call (out of hours)	Covers out of hours operation 18:00 – 08:30, and Saturday, Sunday or Bank Holidays. Rota is made up of staff at Director / Associate Director level. Silver On-Call is the single point of contact for Gold out of hours, and all day during the weekend and on Bank Holidays. Hands over to the System Lead during the week, or Silver On-Call if during a Saturday, Sunday or Bank Holiday.
System Lead rota (in hours)	Covers sites during the day 08:30 – 18:00 Rota is typically made up of Secondary Care members such as acute care directors, hospital directors, experienced Directorate General Managers (DGMs). The System Lead will ensure that actions are in place for handover to the Silver On-Call cover. Silver On-Call will also hand over to System Lead at the beginning of their shift, or Silver On-Call if during Saturday, Sunday or Bank Holiday.
Bronze on call (site specific) (out of hours)	Covers out of hours operation 18:00 – 08:30 Monday to Friday and 08:30 – 08:30 during weekends and Bank Holidays. Rota is typically made up of Directorate General Managers, Matrons, Lead Managers etc. Bronze on-call covers operational issues at each site.

2.3 In addition to the above, there are a number of other rotas:

- Matron of the Day rota (by site).

- Mental Health and Learning Disabilities have their own on-call rotas/escalation, with a Bronze rota (covering out of hours) and Silver rota (covering daytime hours).
- There was a Senior Manager of the day rota in operation between December 2021 to February 2022 due to operational pressures, this has now been stood down.

2.4 We are advised that over the last 12 months, the Silver On-Call rota duty has become more onerous, with a requirement to manage the system into the night and early morning on occasions due to unscheduled care pressures, peaks and troughs in the Covid-19 demand, together with infection prevention issues due to outbreaks. The Silver On-Call role is currently used to manage business as usual pressures across the Health Board system, rather than incident management.

2.5 There is a Tactical Control Centre battle rhythm, which provides detail of the structure, reporting and escalation requirements, and this is used as part of business as usual or escalated pressures.

2.6 When planning the audit, we are advised that a review of on-call arrangements had commenced, however, following a change in senior staff this has not been completed and there are currently no plans to review on-call arrangements. A number of staff stated they were awaiting the outcome of this review.

2.7 As part of our questionnaire we asked staff:

"Are you aware of any BCUHB guidance documentation or policy outlining the requirements for compensation and compensatory rest for on-call sessions?"

Of the 62 responses:

- 30 (48%) answered 'Yes'
- 32 (52%) answered 'No'

2.8 Comments received highlighted the following issues:

- No official guidance to suggest you can come in later to ensure you are not working 16+ hours
- Staff are aware of some all-Wales principles but have not received any BCU guidance
- A number of staff have stated they are awaiting a conclusion to the review of on-call to ensure out of hours is safe, and equitable. Some staff feel current arrangements are not safe, pose risks to staff health, safety and wellbeing, patient safety, and professional registration.
- Some staff have to deal with issues that should have been resolved by managers during the day so it's an extra shift rather than being on-call.

Conclusion:

2.9 There is documentation in place outlining the structure, reporting and escalation requirements, however there is little guidance available for staff on-call providing information on key sites / services that staff may not be familiar

with. We are advised a review of on-call arrangements was started but this was not continued or concluded.

We have concluded **limited** assurance for this objective.

Objective 2: Rota mix

2.10 The majority of issues raised regarding the rota mix refer to the silver on-call rota. This section focuses on that rota, with other rotas referred to towards the end of the section.

2.11 There is no documentation setting out the requirements / expectations for the on-call rotas, such as:

- expected numbers of staff / ratios for the different on-call rotas
- the seniority / experience of staff required
- when rotas are to be produced and issued to staff
- process for being added or taken off the rota to ensure fairness for all staff

2.12 We are advised it is often difficult to fill the rotas and there is reliance on staff goodwill to cover gaps. There have been a number of additions and removals from the Silver On-Call rota since the beginning of 2022. There have been new members added due to vacant posts being filled, but also members leaving due to retirement, Voluntary Early Release Scheme (VERS) as part of the Health Board's new operating model or undertaking additional/other duties. Some members have also been re-instated onto the rota following a period of absence.

2.13 The review exposed a risk that should a serious incident impact the Health Board, it is unclear there is sufficient capacity at senior level for staff to undertake additional activities, with capacity, as advised, already stretched to deliver the 'business as usual' rotas noted above.

2.14 The recent Voluntary Early Release Scheme (VERS) and changes to the Health Board Operating Model will result in a number of individuals currently on the silver on-call rota leaving the Health Board over the coming weeks and months. In addition there is an upcoming retirement and the potential for more than one member to be granted approval to be removed from the rota in the short term, which may result in the rota falling below 1:25. Due to the sensitivity and nature of the changes, the Head of the Tactical Control Centre is reliant on staff advising that they will be leaving the Health Board. Consequently, the ability to forward plan for the change in rotas is inhibited.

2.15 Silver on-call rotas cover around 4 months ahead and are issued to staff via e-mail. Where there are unforeseen changes i.e. sickness, staff are requested to cover these shift at short notice using the Silver On-Call sickness ladder. However, at times, it is difficult to fill gaps at short notice. The rota includes the contact details of those staff who are on-call, and also details future shifts. We are advised that the rota mix varies and will depend on the seniority and experience of those staff on the rota.

2.16 Other rotas

We discussed the Gold and Womens on call rotas with those who administer them. There are some similar issues, such as relying on staff goodwill to fill gaps and no documented process for the completion of rotas. However, they do not have issues with the number of staff changing, nor equality of staff on the rota, with all relevant staff (i.e. Executive for on-call and 8a and above for Womens) included on the rota. Womens also have an on-call pack for staff who are added to the rota.

2.17 We viewed a sample of rotas to establish the current ratio. These are shown in the table 2 below.

Table 2 –On-call rota ratio (as of 20 April 2022)

Rota	Ratio	Comments
Gold on call	1 in 11	
Silver on call	1 in 30	Potential this will become less than 1 in 25
System lead rota	1 in 8	Reducing to 1 in 7 due to VERS
Bronze - Wrexham	1 in 28	
Bronze – Ysbyty Gwynedd	1 in 28	
Bronze – Ysbyty Glan Clwyd	1 in 26	
Matron of the Day – Centre	1 in 11	
Matron of the Day – East	1 in 11	
Matron of the Day – West	1 in 13	
MH Bronze	1 in 34	
MH silver (in hours)	1 in 9	
Womens (in hours)	1 in 10	

2.18 As part of our questionnaire we asked staff:

"Are you provided with sufficient notice for on-call sessions"

Of the 62 responses:

- 57 (92%) answered 'Yes'
- 5 (8%) answered 'No'

2.19 Comments received highlighted the following issues:

- Inequality with staff who are on the rota (i.e. staff of a similar grade are not on the rota), with no understanding of why they are not included
- Not enough staff on the rota
- Concerns that current arrangements are not safe, pose risk to staff health, safety and wellbeing, especially on weekends and Bank Holidays.
- Sometimes the rota comes out late and there are a lot of swaps that have to be made, however staff felt that colleagues were very supportive in making the swaps

- As people leave the organisation the on-call shift becomes more frequent and calls for cover more often.

Conclusion:

2.20 Overall, there is lack of a documented process for the make-up of the rotas, including the required ratio, skills required and processes for staff being added to or being removed from the rotas. Senior staff leaving the organisation will have an impact on the rotas, some of which are already difficult to sustain.

We have concluded **limited** assurance for this objective.

Objective 3: Compensatory rest periods

2.21 The Health Board Rostering Policy (WP28) refers to compensatory rest periods. "*When staff are called into work, they will be entitled to compensatory rest, in line with the Health Board guidance (insert details). It is not acceptable for on call shifts to be regularly rostered before a day off in order to avoid the need for compensatory rest.*" This document also refers to Compensatory Rest Guidelines – BCU Interim guidelines approved at the Local Partnership Forum on Tuesday 14th of October 2014. These are not available on the staff intranet site; however they are included in the Health Board Working Time Procedure (WP21) as an appendix. This sets out examples of time spent on call and the compensatory rest required following the shift. The Health Board Time off In Lieu procedure (WP35) also refers to staff choice to take TOIL instead of payment for on call.

2.22 All the Workforce documents reviewed as part of the audit are overdue for review:

Table 3 – Workforce policies referred to within this review

Document	Date published	Date due for review
WP28 Rostering Policy	December 2014	December 2019
WP 21 Working Time Procedure	March 2015	March 2018
WP35 Time off In Lieu Procedure	February 2014	November 2016

2.23 As part of our questionnaire we asked staff the following questions:

"Are you aware of the requirements for a compensatory rest period following on-call?"

Of the 62 responses:

- 32 (52%) answered 'Yes'
- 30 (48%) answered 'No'

"Do you take compensatory rest periods following an on-call session?"

Of the 62 responses:

- 10 (16%) answered 'Yes'

- 52 (84%) answered 'No'

"How are your compensatory rest periods managed?"

Of the 62 responses:

- 19 (30%) answered 'Informally – via own records / diary'
- 6 (10%) answered 'Formally – i.e. submission of request / rosters (paper or roster system'
- 37 (60%) answered 'Never received / taken a compensatory rest period'

2.24 Comments received highlighted the following issues:

- All staff were not aware of the entitlement to compensatory rest.
- Staff found it difficult to take compensatory rest due to work commitments.
- Some staff take informally i.e. starting shift later.
- Some staff feel it is not worth taking compensatory rest as it impacts on their work commitments.

Conclusion:

2.25 The requirement for compensatory rest periods is set out in various Health Board policies, although these are all overdue for review. Almost half of staff who responded to our questionnaire were not aware of these requirements. The majority of staff do not take compensatory rest periods, with a number citing they did not have the opportunity to take these. Where these are taken, they are often informal (i.e. late start / early finish). If staff are not able to take compensatory rest periods this could impact on staff wellbeing, tiredness and patient safety.

We have concluded **limited** assurance for this objective.

Objective 4: On-call payment arrangements

2.26 Payment arrangements for on call are set out in the 2012 guidelines available on the Health Board intranet site. Senior Staff (Silver / Bronze / Executive) claim payment for on-call via the *All Wales On Call Claim Form* which is available on the Health Board intranet site. This is submitted by their line manager.

2.27 Other staff claim payment for on-call in the following ways:

- Staff live on the rostering system

  Managers record the on-call times on the rostering system which when the roster is signed off links to the payroll system for payment.

- Areas not live on the rostering system

  The manager submits the *Departmental On Call Return (All Wales)* monthly to payroll. This details individual staff detailing on call sessions and emergency work.

2.28 As part of our questionnaire we asked staff the following questions:

"Do you claim payment for on-call?"

Of the 62 responses:

- 48 (77%) answered 'Yes'
- 14 (23%) answered 'No'

"Is the payment you receive for on-call correct and processed in a timely manner?"

Of the 48 responses:

- 45 (94%) answered 'Yes'
- 3 (6%) answered 'No'

2.29 Comments received highlighted the following issues:

- Some staff are not aware of the being able to claim a payment for being on call.
- Guidance was circulated 'many years ago'.
- Some staff feel that payment received for on-call is poor in comparison to the amount of work that is expected.

Conclusion:

2.30 On-call payments for staff are claimed via completion of forms submitted to payroll or via the rostering system. The majority of staff who responded to our questionnaire claim payments for on-call and are paid correctly, however some were unaware of the payments due.

We have concluded **substantial** assurance for this objective.

Objective 5: Staff training

2.31 There is no documented / formal training available for staff who are included in the on-call rotas, with the exception of Womens who provide an on-call pack to staff. There is separate training on Emergency Preparedness Resilience and Response, which has not been covered by this audit. We are advised some informal training may take place i.e. shadowing a colleague.

2.32 A number of staff advised they are often dealing with areas they are not familiar with. It is important that staff have relevant information available to them for the sites they are covering that they may not be familiar with (i.e. crib sheets outlining key services, where the discharge lounge is etc.).

2.33 As part of our questionnaire we asked staff:

"Have you received any training / guidance on the structure / decision making or had the opportunity to shadow a colleague on call?"

Of the 62 responses:

- 45 (73%) answered 'Yes'
- 17 (27%) answered 'No'

Conclusion:

2.34 There is training available for staff in relation to Emergency Preparedness Resilience and Response, however as the requirements for on-call are not documented it is not clear whether on-call staff require this training and how

that is captured. There is no formal training for staff included in the majority of business as usual on-call rotas reviewed.

2.35 We have concluded **limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1 – Review of on-call arrangements (Design)	**Impact**
We are advised that a review of on-call arrangements was previously started, however this has not been completed. Several concerns have been highlighted by staff through the questionnaire, with many stating they are awaiting the outcome of the review that 'has been ongoing for a number of years'. On-call arrangements are clearly an emotive subject amongst staff who are included on the rota, with staff stating the risks of the current arrangements, i.e. staff burnout, inability to take rest impacting on staff, the pressure and workload for an on-call shift. There is a Tactical Control Centre battle rhythm, which provides detail of the structure, reporting and escalation requirements, and this is used as part of business as usual or escalated pressures, however there is little guidance available for staff on-call providing information on key sites / services that staff may not be familiar with.	Potential risk of: • on-call arrangements are not equitable or sustainable, impacting on staff wellbeing and patient safety.
Recommendation	**Priority**
The on-call review should be re-instated as a priority, to ensure arrangements match service requirements, and are reviewed considering changing needs as a result of changes due to VERS and the new Operating Model. Management should consider the feedback from our questionnaire when reviewing on-call arrangements, and how these can be addressed. Following completion of the review and update of guidance (see Matters Arising 2,3 and 4 below), this should be communicated to staff to ensure they understand their obligations and responsibilities for participating in the on-call rotas.	High

Agreed Management Action	Target date	Responsible Officer
1.1a The on-call review will be restarted and will be led by the Interim Regional Director of Delivery (IRDD), supported by the Strategic Emergency Preparedness Response and Resilience (EPRR) lead.	20th June-23rd September 2022	Interim Director of Regional Delivery
1.1b Proposals will be presented to the Executive Team, for approval.	12th October 2022	Deputy Chief Executive Officer

Matter Arising 2 – Rota guidance / sustainability (Design)	**Impact**
There is no documented process for the make up of the rotas, including the processes for staff being added to or being removed from the rotas. Considering there is a reliance on staff goodwill there should be tighter controls around ensuring staff who are in a relevant role are included on the rota, to ensure fairness. Senior staff leaving the organisation following the Voluntary Early Redundancy Scheme, and changes as a result of the new Operating Model, will have an impact on a number of rotas, some of which are already difficult to sustain.	Potential risk of: • Rotas are not sustainable, impacting on patient safety and staff wellbeing.
Recommendation	**Priority**
The following should be documented for on-call rota's: • Minimum staff numbers. • Seniority / experience mix. • Timelines for preparation and issuing of rotas. • Frequency and type of each employee's commitment is equitable. • Process for staff being added to the rota when commencing an applicable senior role.	High

• Process for staff being removed from the rota, ensuring the impact this will have on other staff is considered, with reasons approved at an Executive level. Any staff removed from the rota should be reviewed regularly to determine if they can be put back on it.		
Agreed Management Action	**Target date**	**Responsible Officer**
2.1 On-call document, covering the recommendations above will be issued to all staff.	1st July 2022	Interim Director of Regional Delivery

Matter Arising 3 – Compensatory rest and payment (Operation)	**Impact**
Almost half of staff who responded to the questionnaire were not aware of the entitlement to compensatory rest (based on hours worked during on-call). 84% of the staff who responded do not take compensatory rest. Whilst compensatory rest is outlined within an appendix of the Working Time policy, this information is not easy for staff to find. The workforce policies that include reference to on-call and compensatory rest are overdue for review. Payment for on-call is claimed in the same way as overtime etc. and staff who responded received the correct payment for on-call worked. There were however some staff who are not aware of the payments they are entitled to.	Potential risk of: • detrimental impact on staff wellbeing and the ability to provide safe, effective care to patients.
Recommendation	**Priority**
Workforce policies to be reviewed and updated as necessary, including clear guidance on the requirement for taking compensatory rest.	High

Guidance on compensatory rest and payment entitlement to be included on the staff intranet site and circulated to all staff included on on-call rotas. This should be done on a periodic basis to ensure new staff who are added to rotas are aware of their entitlements. Staff included in on-call rotas to be encouraged to take compensatory rest.		
Agreed Management Action	**Target date**	**Responsible Officer**
3.1a All on-call staff to be written to by the Interim Director of Regional Delivery, having agreed content of the letter with the Director of Workforce & OD, and Deputy CEO. *Audit notes:* - *The Rostering Policy has been reviewed and is with the Workforce Policy Group for consideration (action captured through the review of Nursing Roster Management)* - *re guidance on compensatory rest / payments - see action 4 below - manual with key information for staff to include this information.*	11th July 2022	Deputy CEO

Matter Arising 4 – Training (Design)	**Impact**
There is a lack of documented / formal training available for staff who are included in the business as usual on-call rotas. We are advised some informal training may take place i.e. shadowing a colleague. A number of staff advised they are often dealing with areas they are not familiar with. It is important that staff have relevant information available to them for the sites they are covering which they are unfamiliar with (i.e. crib sheet outlining key services, where the discharge lounge is etc.).	Potential risk of: • staff may be unaware of the actions that need to be undertaken during an on-call shift.
Recommendation	**Priority**

The requirements of staff included in on-call rotas should be documented and staff provided with relevant information to ensure they are able to deal with expected issues whilst on-call i.e. key information about sites and services, as staff may not be familiar with the site they are responsible for during the on-call shift. Training should be provided to staff who are on the rotas to ensure they are aware of their responsibilities and possible scenarios of what they may have to deal with.	High	
Agreed Management Action	**Target date**	**Responsible Officer**
4.1a Programme of training to be reviewed. The programme will take into account the areas identified within the audit survey.	28th September 2022	Interim Director of Regional Delivery
4.1b Manual to be developed with key information, and details for those on call.	24th October 2022	
4.1c All staff to receive training with a programme and timescale set for refresher training every two years.	12th December 2022	
4.1d Real time log to be introduced for all levels of on-call to aid action learning with a rolling process of review by the IRDD and Strategic EPRR lead.	10th September 2022	

Appendix B: Staff on-call questionnaire feedback

General Comments

- The **stress** of undertaking the role impacts on my ability to undertake my actual role, and so is in turn having a detrimental **impact on the service** that I manage.
- Over the last 12 months the time required to take part in the on-call rota has increased as has the **operational pressure** across the system.
- On a weekday on-call we have to do our own job and pick up bed management meetings as well. We also have to **work straight through** to next morning and work again the next day in our normal roles. This is **exhausting** if you have had calls during late evening and through the night. This also can occur on Sundays when you have to do 24 hours on call and then have work on the Monday. Also we are now expected to complete a handover sheet the morning after our on-calls which means an early start even if you are not contacted.
- It is **extremely difficult to take any rest** post on call due to the nature and expectation of our substantive jobs . If on call was true on call where we were expected to respond to any unplanned or exceptional circumstances as per A4C describer it would be manageable , however on call has a number of planned calls and expectations and currently an uninterrupted night is rare . You can work for 24 hrs with no opportunity to rest at weekends in a **highly stressful** environment , this is causing **physical and mental anxiety** that is not recognised and personally is causing a **feel of dread** pre on call . We have been advised that on call is being reviewed for the last 5 or more years but **no outcome** even though **significant concerns** have been raised by participants.
- It is not clear why some people are on call and some are not when they are at a senior level , **equity and fairness does not seem to be considered**.
- **There have been numerous reviews and promises to address the concerns that we have all been reporting and escalating for many years regarding the responsibility and role expectations of being Silver**. The role has changed significantly over the years, with the last 6 or 7 years or so seeing us managing unscheduled acute hospital pressures rather than having an on-call role as it was intended. Managing and tolerating **increasing levels of risk**, with sites at level 4 as the norm. Many of us left on the Silver on-call rota do not manage acute services as our day jobs so are not the expertise needed out of hours when all the infrastructure of senior support is absent, it's the perfect storm ... increased demand at the front door after 5pm, senior management and clinical staff have finished for the day and the least experienced managers take over as Silvers. We have advised many times that a **senior management layer needs to be put in place** on the acute sites to manage unscheduled care out of hours, then the role of Silver would be safer and 'on-call', not as it is now which is a 24-hour shift. We are in a critical situation as more people leave the organisation and the rota with no new people joining it, so doing the on-call shift is becoming more frequent and calls for cover

more often. It isn't safe now and is going to get worse very quickly, and it certainly isn't the right model for patients and for staff.

- Highly pressured environment to work in
- as Gold on call….I do not find on call to be burdensome nor to I require time or financial recompense
- often calls relate to actions that **should be completed in the day** by the managers present in those areas.
- expected to complete on call tasks in the day following bed calls where this is not your area of working and have to also do day job. This **adds to work stress and over load**. No compensated time to allow you time to do this. On call is often not on call and when finishing work can be often on the phone from 5pm till post 9pm solid and then calls throughout the night, sometimes to authorise something that should have been agreed in the day by managers.
- if working Sunday- Thursday on call - then this **hugely impacts on your performance the following day** due to **tiredness** from being up throughout the night. Often **inaccurate information** being handed over from bed calls and areas not working together as one. Being on call is **very stressful recently**.
- On call review must be re-energised and concluded asap. There are many staff in the organisation who should be on the on-call rota for Silver, however many, many years later we are still waiting a satisfactory conclusion of our concerns, to ensure cover out of hours is safe, and equitable.
- Current arrangements are **not safe**, pose **risks to staff health**, safety and wellbeing, **patient safety**, and **professional registration**, especially weekends and Bank Holidays, which are not on call but full working days. Health is a 24/7 service therefore operational arrangements out of hours should reflect this, to include the most appropriate staff, with the knowledge skills and competence to manage operationally out of hours.
- It's not really on-call as there is often an **expectation of you being on site** by the silver.
- Often the calls for Bronze on call begin minutes after 5pm, the calls relate to issues that should have been resolved before the service managers leave their shift as they are often **issues that have been ongoing for hours**. Contingency plans are often inappropriate if there are any contingency plans at all. The duty nurses can at times be brittle, often because of the situation they have been left in by their managers.
- We are asked to be bronze on call out of our service area, this is at best impractical, at worst **unsafe**, we are asked to manage situations that we have no working knowledge around. On call impacts significantly on or working days as Bronze on call. We are expected to attend Tactical Control Centre site capacity meetings and report back on areas that have service managers on shift at that time. Service managers should be attending these calls to answer and queries, we are picking up

additional work that should be carried out by the site managers as well as our day jobs.

Guidance

- No official guidance to suggest you can come in later when on call to ensure that you are not working 16+ hours.

- **Not seen any BCU guidance** although aware of some all-Wales principles through own searching.

Rota mix

- there seems to be **inequity** with the rota itself - I am aware there are colleagues of a similar grade that are not on the rota and find it difficult to understand why.
- No thought given for annual leave and wellness of staff - unable to pre advise of annual leave for the year therefore need to find swaps for on calls which adds to **stress**.
- **Inconsistent application** across BCU so small number of senior managers do significantly more of the on call whilst others do none, We need to be empowering our CSM teams to do more (staff and pay them properly for the responsibility they have and release the bronze on call to support their own roles) Split weekends as a long day on Saturday or Sunday wipes you out for the rest of the weekend as it is relentless

Compensatory rest

- On Call has changed since I first started doing it. It has become a **time-consuming** job in itself. Difficult to take restorative rest periods due to other work commitments.
- Compensatory rest periods - this is something I have only done very occasionally but am trying to ensure I diarise it when I know I am on call.
- Compensatory rest is not usually taken as the on call is on top of day job, not instead of and **taking compensatory rest is not always possible**.
- As an operational manager the on-call arrangements impact on my day job. In the past I tried to do my full day job plus on call but this became impossible due to the long hours spent on call especially in the evenings. A shift system was introduced but this was removed. We are able to work a shift system if we want to but if we do this we feel guilty about not coming in for our day job. I usually come into work about 10am or 11am and one of the more recent on calls I did I was here until 2am. I do feel that it is **not safe** sometimes for us to be working such long hours. On leaving at 2am I then received a phone call at 4.30am. The next day was Saturday so I was able to rest but lost most of my Saturday as a result. Compensatory rest isn't applicable at weekends.

- I am **not always able to take due to diary commitments** and senior nurse cover
- Wasn't aware of any compensatory rest time. I have been onsite from 9am and remain on-site for 18hrs+. There is an expectation that you return to work the following day. I am sure that if you were to contact the site the following day, annual leave would be authorised if so requested.
- I do not take full allowance and have to fit it in between commitments, so cannot take straight after on-call. On-call system requires revision urgently, **high clinical risk.**
- Very difficult to take compensatory rest owing to work load demands
- Also feel a rest period should be facilitated as it can be very tiring doing day job all day then on call which can be busy and day job next day. High pressure at times.
- I find that not enough issues from the day are escalated from acute mental health services . Also when have to balance work life balance it can be difficult to balance without rest period. I feel there is a **high expectation** and **not enough on rota** from same banding as myself
- I am aware of the rules for taking compensatory rest after on call but don't normally take compensatory rest per se. Rather, if it has been a difficult and long evening/night up getting to bed very late, I will start work a little later the following day and then sometimes work longer the next day/day after that to catch up. Compensatory rest doesn't apply if on-call on a Friday night or Saturday.
- Compensatory rest is informal, sometimes **not worth taking as your diary suffers**

On-call Payments

- The on-call arrangements have changed dramatically since I commenced completing on call in 2012. The requirements to attend calls, complete documentation , send reports and expectation to support areas out of hours are **not on call they are a working shift** which is extremely difficult to compensate time wise and only financially compensated by including hours of activity.
- Often we have missed payments for on-call and are chasing payroll for the payment
- I have only recently been made aware of the on-call payment process and have placed a claim this week.
- neither of the above *(Compensatory rest / payment)* was made clear when I commenced on call.
- Payment is claimed in line with guidance, again circulated many years ago in an email.
- The payment received for on-call is poor in comparison to the amount of work that is expected. it very much feels like an **extra shift** rather than an on-call.
- I was **never informed of pay arrangements** and how to claim for the on-call role, and have never claimed.

- On call payment does not truly reflect the hours of work committed when on call.

Training

- **No support or training** given. Shadowed 2 on call sessions. Neither of which had any calls so didn't give any real insight into the decision-making process.
- No fire or major incident training given so would be unsure what to do in this scenario.
- training provided over 5 years ago. **no update** since changes within the organisation
- My induction onto the on-call, was one half day training session around 6 years ago and being buddied the 1st time I did on-call.
- **shadowing** - this was arranged individually rather than it being a formal induction to on-call.
- I have attended one on call meeting where there was a discussion about the on-call resources on the website - these are however quite **out of date** and need some focus. I would also advise that training needs to include access to all relevant IRIS reports as I have had to find these in informal discussions with colleagues.
- there is **no formal on call pack** apart from the rotas - we could do with there being a formal on call pack that can be accessed with all relevant rotas plus contact numbers and examples of "what to do if"

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Business Continuity Plans
Final Internal Audit Report

June 2022

Betsi Cadwaladr University Health Board

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

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

Contents

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Executive sign-off:	Deputy CEO / Executive Director of Integrated Clinical Services
Distribution:	Emergency Preparedness, Resilience and Response Lead Head of Emergency Preparedness, Resilience and Response Business Continuity Manager
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The purpose of the review was to assess the status of Business Continuity Plans and sample a number of areas to ascertain their effectiveness in accordance with Health Board policies/procedures.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- The Business Continuity Group have only met three times in two years. Attendance to the Working Group means that only one of the meetings in the last two years were quorate.
- Of the expected 122 Business Continuity Plans for areas across the business, only 38% (47) have been finalised.
- There is a lack of local engagement across the Health Board. This encompasses development of local plans, engagement in training, regular review and testing of plans already in place.
- A formal escalation route with Executive ownership has recently been put in place, however we have not seen this in operation.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	 2018/19

Assurance summary[1]

Assurance objectives		Assurance
1	Governance Arrangements	Reasonable
2	Business continuity plans	Limited
3	Visited and Reviewed Plans	Limited
4	Tested and Assessed Plans	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	The Business Continuity Working Group has not met frequently, with only one meeting quorate in the last two years.	1	Operation	Medium
2	There is a lack operational engagement in BC planning. The majority of areas where plans are expected do not have finalised plans, and there is little evidence of regular review and testing of the plans.	2/3/4	Operation	High
3	A formal escalation route with Executive ownership has recently been put in place, however we have not seen this in operation.	2	Design	High

1. Introduction

1.1 NHS Organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential and business critical services will be maintained, with normal services restored as soon as possible.

Business Continuity Planning is an integral part of the Business Continuity Management (BCM) process. The Business Continuity Plan (BCP) provides a framework in which the Health Board responds to maintain 'business as usual'.

Each area of the Health Board should have BCPs in place to ensure the continuity of service they are providing, with each plan setting out prioritised objectives in terms of the activities to be recovered, the timescales in which they are to be recovered, and the recovery levels for each critical activity. Each BCP should be regularly visited for relevancy, with any system changes addressed, all staff should be made aware of the process to follow and key staff involved. In addition, BCP should be routinely tested for effectiveness.

1.2 The scope of the review was to assess the status of Business Continuity Plans and sample a number of areas to ascertain their effectiveness in accordance with Health Board policies/procedures. To achieve this, the review assessed the following objectives:

- There are effective governance arrangements in place;
- Business continuity plans are in place, and made available to relevant staff;
- Business continuity plans are routinely visited and reviewed ensuring they reflect current practices and systems; and
- The latest Business Continuity Plan has been tested and assessed for effectiveness.

1.3 The key risks considered during the review were:

- Health Board is not able to maintain "regular service"; and
- Possible delay in patient care / treatment / administration / diagnosis.

2. Detailed Audit Findings

Objective 1: There are effective governance arrangements in place.

2.1 The review of Governance Arrangements ascertains whether the Emergency Preparedness and Resilience department has adequate processes in place to ensure:

- The department has clear reporting lines;
- Policies and procedures are available and are routinely reviewed;
- Tools are in place to support Areas/Department/Divisions in delivering local Business Continuity Plans (Training, templates, tools, point of contact etc.)

The Health Board has an Emergency Preparedness, Resilience and Response

(EPRR) department which sits within the Deputy Chief Executive / Executive Director of Integrated Clinical Services portfolio.

The department consists of the EPRR Lead, Head of EPRR and a Business Continuity (BC) Manager.

2.2 Documents and Training material have been made available to all staff via the Resilience Home Page on BetsiNet (the Health Board intranet site). These include:

- Departmental BC Documents – including Policy / Training / Templates and Plan Repository (29 plans were included in the Repository);
- Business Impact Analysis (BIA) Template;
- BCP Template; and
- BCP Checklist.

Policies and Guidance Documents were up to date these include:

- Business Continuity Management Policy V02;
- The Good Practice Guidelines (GPG) 2018 Edition (Definitive guide for business continuity and resilience professionals); and
- Departmental Lead Profile.

2.3 Business Continuity Working Group

There is a Business Continuity Working Group that meets bi-annually. The group consists of the EPRR Team along with departmental BC leads and Risk Management. The Group is chaired by the Head of Emergency Preparedness and Resilience and reports directly to the Civil Contingencies Group.

We reviewed the Terms of Reference (ToR) for the Business Continuity Working Group and note that not all BCP leads are named in the membership (noted as '*Health Board Business Continuity Leads*'). There is however a separate list of named leads that are down as members.

It is difficult to establish if meetings were quorate as the ToR states "*A quorum of 50% has been established though the group unless the nominated representative is unable to attend then a suitable alternative representative may attend on their behalf*". [sic] Therefore, in order for the Group to be quorate, there would need to be a minimum of 25 members in attendance.

2.4 A review of minutes shows the following attendance of the 48 required attendees (plus the Head of Emergency Preparedness and Resilience Business Continuity Manager):

	Meeting October 2020	Meeting March 2021	Meeting October 2021	Meeting March 2022
Attendance (+Chair/Deputy Chair)	14 (2)	15(2)	No Meeting	23(2)
Apologies	6	9		4
BC Leads Updates by exception	0	0		2

2.5 Although there seem to be issues in the Areas/Divisions/Departments in compiling/implementing BC plans, only two issues had been raised in the working group by BC Leads and noted in the minutes over the last two years under the agenda item *BC Leads updates by exception*, one of which related to an incident.

2.6 In March 2022, the Business and Planning Manager in the Central Area raised a concern that the group had not met for a year and feeling out of the loop with BC and unaware as to where things are up to. The Head of Emergency Preparedness and Resilience reassured the Group that they are in the process of meeting leads to refresh and restart the process. It was too early following this report to corroborate whether this was being undertaken.

2.7 Business Continuity Training commenced in May 2021 and at the time of the review sixty-six of the ninety-six members of staff had received training. The remaining thirty staff members that were unable to attend previous dates and/or registered to attend but then had to cancel attendance on the day have received an email informing them of their options.

Conclusion:

2.8 The Business Continuity Team provides detailed guidance and training for Business Continuity Leads that sit within areas across the Health Board. There is a Business Continuity Working Group in place, however this does not meet regularly to provide leads with the opportunity to raise concerns formally.
We have concluded **reasonable** assurance for this objective.

Objective 2: Business continuity plans are in place and have been made available to relevant staff (Locality arrangements).

2.9 In order for Business Continuity Leads within each area to create a Business Continuity Plan (BCP), they must first complete a BIA which defines the BCP (Policy states the BIA is reviewed annually or in light of significant change to service or any lessons learnt). The results of the BIA will inform the content of the BCP. The Business Continuity Manager will meet with the BC leads to review and finalise these documents and again on an annual basis or where any change occurs. As mentioned above, all the tools required to create a Local Business Continuity Plan is readily available and up to date on BetsiNet as well as support if required from the Business Continuity Team and Guidance documents.

2.10 The Emergency Preparedness, Resilience and Response (EPRR) Team hold a list of all prioritised activities that required a business continuity plan. We checked that each had a corresponding Business Impact Assessment (BIA). We also looked to identify of the plans that had been drawn up, whether they were in draft version (work in progress) or finalised and approved.

2.11 Result were as follows:

Expected Number of Plans	Plan not started	Plan Work in Progress	Finalised Plans
122	40 (33%)	35 (29%)	47 (38%)

2.12 Of the forty-seven finalised BCPs only thirty-three were available on the Business Continuity Plan central repository on BetsiNet.

2.13 We took a sample of nine plans to establish whether a paper copy was held on site and of the nine all were available in hard copy located on site.

2.14 The BC Team use a tracker that lists all plans and notes the last time progress was chased and the reasoning behind any delays, these included:

- No contact since meeting despite follow up emails
- Delay due to change in lead
- Delay due to meeting not attended in March
- Workshop scheduled for 04/05/2022 - had to rearrange as not all could attend, now scheduled for 17/05/2022
- Awaiting update

2.15 At the time the review, the escalation route for delays in implementing Business Continuity Plans were not effective. The identified route of escalation is that the Leads report to the Business Continuity Working Group, who report to the Civil Contingencies Group, who reported to the Strategy Partnerships and Population Health (SPPH) Committee (which has superseded by the Partnerships, People and Population Health Committee). However, the last report (17th June 2021) to the SPPH informed that there were no issues in relation to Business Continuity and all actions were reported as being "On track" (*no real concerns/continuous programme for example training & exercising*). No updates have been provided to the PPPH Committee.

2.16 Since the review was undertaken, we have been provided with Terms of Reference for the newly established Civil Contingencies Assurance Group which we are advised the Civil Contingencies Group reports to – We cannot see the Civil Contingencies Group included in the Terms of Reference as a direct report and are unable to confirm that the new Assurance Group has met or that its Terms of Reference have been formally approved by the Executive Team.

Conclusion:

2.17 There is a lack of engagement in embedding business continuity arrangements at a local level. We understand that the last twenty-four months have been difficult for the Health Board in terms of capacity and staff availability. A review of the local Risk Registers shows that BCP appears as both a risk and mitigation, however, are still outstanding following COVID-19 disruptions.

2.18 There is a lack of clarity and ownership in the escalation process, and a disparity between what is clear in the number of recorded plans not completed and the assurance provided to the Board through its committees.

We have concluded **limited** assurance for this objective.

Objective 3: Business continuity plans are routinely visited and reviewed ensuring they reflect current practices and systems. (Locality arrangements)

2.19 The EPRR Department maintains a Plan Tracker Spread Sheet. From this we were able to identify the review dates of live plans in order to ascertain whether they are routinely visited and reviewed. We are advised the Business Continuity

Team use the tracker to contact areas to confirm if their plans have been updated. Records show:

- Thirty were due for review
- Sixteen were reviewed in the last year
- One was in the process of being reviewed

2.20 The EPRR Department provides support and guidance to the individual Areas by assisting them in compiling and reviewing BCPs when required, it is not the EPRR Department's responsibility to review the current practices, systems and processes for accuracy, this is the Service Area/Team/Department's remit.

2.21 Following recent disruptions due to COVID related issues, Business Continuity should be high on every department's agenda and appear on the departmental risk register should they not have one in place or reviewed to reflect the most current practice.

Conclusion:

2.22 We found that of those Business continuity plans that are in place many are not routinely visited and reviewed and therefore may not reflect current practices and systems.

We have concluded **limited** assurance for this objective.

Objective 4: The latest Business Continuity Plan has been tested and assessed for effectiveness. (Locality arrangements)

2.23 Discussions with the Emergency Preparedness, Resilience and Response (EPRR) Team indicate that, of the forty-seven BC plans in place, they are only aware of a limited number of Plans that have undertaken a full live test.

2.24 The EPRR team have been told that limitations to the testing are mainly due to a department's time and/or staffing.

2.25 Of the forty-seven approved BCPs, the Emergency Preparedness, Resilience and Response (EPRR) Team have only a record of three Areas where full testing has taken place, these are:

- Acute Paediatric Services (all sites) - July 2021
- Theatres YG - Nov 2021
- IT BC exercise - 1st April 2022

2.26 Plans are owned by the services however the EPRR Department is required to record when training has been provided and the plans have been tested locally.

2.27 The EPRR Department reports directly to the Civil Contingencies Group (CCG) who have "*Business Continuity Update and Monitoring Report*" as a standing Item on the Agenda. Here they receive updates on any plans that are tested, we would expect the Business Continuity Update and Monitoring Report to the CCG to include whether or not plans have been tested as a Key Performance Indicator (KPI).

Conclusion:

2.28 We found there to be limited recording and reporting of testing the Business Continuity Plans at a local level. Without testing and reporting of the results there is no way of knowing that the BCP is effective in achieving its objective. There is also a lack of reporting on whether plans have been tested.

We have concluded **limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Business Continuity Working Group (Operation)	**Impact**
There is a Business Continuity Working Group that meets bi-annually, the group consists of the Resilience Team along with departmental BC leads and Risk Management, the Group is chaired by the Head of Emergency Preparedness and Resilience and report directly to the Civil Contingency Group. However this group has only met three times in the last two years. A concern was raised in the group had not met for a year and felt out of the loop with regards to BC and unaware as to where things are up to. Although there seem to be issues in the Areas/Divisions/Departments in compiling/implementing BC plans, only two issues had been raised in the working group by BC Leads and noted in the minutes over the last two years under the agenda item BC Leads updates by exception, one of which related to an incident. We reviewed the Terms of Reference (ToR) for the Business Continuity Working Group and note that not all BCP leads are named in the membership (noted as 'Health Board Business Continuity Leads'), also any changes to roles/attendees should be amended in the Terms of Reference and approved by the Group as soon as practicable. There is however a separate list of named leads that are down as members. It is difficult to establish if meetings were quorate as the ToR states "*A quorum of 50% has been established though the group unless the nominated representative is unable to attend then a suitable alternative representative may attend on their behalf*". Therefore, in order for the Group to be quorate, there would need to be a minimum of 25 members in attendance, this has not been the case.	Potential risk of: • Lack of leadership/ownership; • Low importance placed on Business Continuity; • Unable to move forward with decisions as meetings not quorate.

Recommendations		Priority
1.1a The Working Group should meet on a quarterly bases in order to capture any concerns promptly and to ensure any issues or concerns are reported to the Civil Contingencies Assurance Group. 1.1b The Terms of Reference should ensure it is transparent in its Membership by clearly listing roles of individuals who should be in attendance. 1.1c The quorum must be clearer as only one meeting in the last two years was quorate. 1.1d The BC Team should ensure they review any outstanding training for the BC Leads and to arrange further sessions as soon as is practicable to do so.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1a The working group is now scheduled to meet on a quarterly basis. The agenda will include a report updating the position on BC plans and will highlight areas of concern. These will be reported to the Civil Contingencies Assurance Group in line with the Terms of Reference.	30th June 2022	Emergency Preparedness Response and Resilience Lead
1.1b The Terms of Reference for the Business Continuity Working Group will be updated to also include a list of individual (job titles) who are required to attend the group.	30th June 2022	Emergency Preparedness Response and Resilience Lead
1.1c The Terms of reference will be updated to include the revised number of members required for the meetings to be quorate.	30th June 2022	Emergency Preparedness Response and Resilience Lead
1.1d The training provision for the BC leads will be reviewed and scheduled to take place from the end of June.	13th June 2022	Emergency Preparedness Response and Resilience Lead

Matter Arising 2: Incomplete Business Continuity Plans (Operation)	**Impact**
The Health Board has one hundred and twenty-two expected Business Continuity Plans listed, however, only forty-seven were complete, forty are yet to be started and thirty-five are work in progress. Of the forty-seven completed plans: • Sixteen were reviewed in the last year; • Thirty were due for review; • One was in the process of being reviewed. Plans are owned by the services and the EPRR Team are not required to record when the plans have been tested locally. The EPRR Team reports directly to the Civil Contingency Group (CCG) who have "Business Continuity Update and Monitoring Report" as a standing Item on the Agenda. Here they receive updates on any plans that are tested, however there is no Key Performance Indicator relating to the testing of plans.	Potential risk of: • Loss of service / no business continuity • BCPs not a reflection current practice • BCPs not operational
Recommendations	**Priority**
2.1a The Health Board's Civil Contingencies Assurance Group should ensure that action is taken to ensure the seventy-five BCPs are drafted and implemented as soon as practicable. A process should be put in place to ensure plans are regularly reviewed and amended whenever any changes are made to local processes. 2.1b Localities should be reporting all tested BC plans to the EPRR Team to ensure assurance can be provided to the CCAG that plans work operationally in the event of an incident. 2.1c The Business Continuity Update and Monitoring Report to the CCAG should include whether or not plans have been tested as a Key Performance Indicator (KPI).	High

Agreed Management Action	Target Date	Responsible Officer
2.1a The Health Board's Business Continuity Management Policy and Guidance Document will reviewed and incorporated into one policy document. This policy will also include the process for reviewing, training, testing and the amendment of plans. Plans will need to be reviewed every 6 months, staff need to be briefed on the plan and the procedures to follow, new staff also need to be trained in the plan and the plan should be tested every 12 months against a range of scenarios.	30th June 2022	Emergency Preparedness Response and Resilience Lead
2.1b Localities need to be advised to report all tested BC plans to the EPRR Team to include lessons identified and action plans	30th June 2022	Emergency Preparedness Response and Resilience Lead
2.1c The Business Continuity Update and Monitoring Reports will include the testing of plans included within the KPIs	30th June 2022	Emergency Preparedness Response and Resilience Lead

Matter Arising 3: Escalation of non-completion of BCPs (Operation)	**Impact**
The Health Board has one hundred and twenty-two expected Business Continuity Plans listed, however, only forty-seven were complete, forty are yet to be started and thirty-five are work in progress. There is a lack of clarity and ownership in the escalation process, with no escalation of non-completion / review / testing of plans beyond the Civil Contingencies Group we found there to be disparity between what is clear in the number of recorded plans not completed and the RAG assurance provided to the SPPH on the position.	Potential risk of: • Loss of service / no business continuity • BCPs not operational

Recommendations	**Priority**
3.1a The new Civil Contingencies Assurance Group (CCAG) is formally established and Terms of Reference reflect direct reporting groups. 3.1b Following a review of outstanding BCPs (see recommendation 2 above), relevant Executives should be provided with the detail of any areas within their responsibility that do not have completed plans.	High

Agreed Management Action	**Target Date**	**Responsible Officer**
3.1a The Terms of Reference new CCAG will reflect the direct reporting groups such as the Business Continuity Working Group and the Civil Contingencies Group	30th June 2022	Emergency Preparedness Response and Resilience Lead
3.1b The arrangements required to provide an escalation process is currently being determined to ensure that the Executives are regularly appraised concerning the localities and departments that do not have completed plans in place	30th June 2022	Emergency Preparedness Response and Resilience Lead

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Head of Internal Audit Opinion & Annual Report 2021/2022

June 2022

Betsi Cadwaladr University Local Health Board

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

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

Contents

Report status:	Final
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Final report issued:	31st May 2022
Author:	Head of Internal Audit
Executive Clearance:	Interim Board Secretary
Audit Committee:	30th June 2022

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Betsi Cadwaladr University Health Board's (Health Board) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

As a result of the continued impact of COVID-19 our audit programme has been subject to change during the year. In this report we have set out how the programme has changed and the impact of those changes on the Head of Internal Audit opinion.

1.2 Head of Internal Audit Opinion 2021-22

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2021/22 is that:

Limited assurance		More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

Due to the considerable impact of COVID-19 on the Health Board, the internal audit plan has needed to be agile and responsive to ensure that key developing risks are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken

sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2021/22 year was initially presented to the Committee in March 2021. Changes to the plan have been made during the course of the year and these changes have been reported to the Audit Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors (in 2018), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work continues to 'generally conform' to the requirements of the Public Sector Internal Audit Standards for 2021/22. For this year, as in 2020/21, our QAIP has considered specifically the impact that COVID-19 has had on our audit approach and programmes. We are able to state that our service 'conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, and in part reflecting the impact of COVID-19, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2021/22

Substantial Assurance	Reasonable Assurance
• Capital Funded Systems	• Statutory Compliance – Asbestos Management

	• Upholding Professional Standards in Wales • Maternity Cross - Border Arrangements • Procurement: Contract Management and Single Tender Waivers • Targeted intervention • Learning Lessons • Voluntary Early Release Scheme (VERS) • Financial Management, Reporting and Budgetary Control • Network and Information Systems (NIS) Directive • Cluster working - Governance • Recruitment – Employment of medical locum doctors • Waste Management • Impact assessments • Risk Management
Limited Assurance	Advisory/Non-Opinion
• Establishment Control: Leaver Management • Standards of Business Conduct • Integrated Service Boards Governance • Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists • Nursing Roster Management: Introduction of e-timesheets for Agency staff • Clinical Audit • On-Call arrangements • Business Continuity Plans	• Security Invoice Review • HASCAS & Ockenden external reports: Recommendation progress and reporting • Secondary Care Division – Ysbyty Glan Clwyd • Follow up - Progress against Healthcare Inspectorate Wales (HIW) recommendations: Mental Health and Learning Disabilities • Temporary Hospitals: Follow up of KPMG recommendations • HASCAS & Ockenden external reports: Recommendation progress and reporting - Workforce • Decommission of Ysbyty Enfys Temporary Hospitals
No Assurance	
• N/A	

Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the

course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by

management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Betsi Cadwaladr University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Limited assurance		More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were eight audits in 2021/22).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2021/22, and reported to the Audit Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).

- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and Inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, one was allocated Substantial Assurance, fourteen were allocated Reasonable Assurance and eight were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. Seven advisory or non-opinion report was also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board's activities that we had previously used to structure our strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken eight reviews in this area.

Standards of Business Conduct – We issued **limited assurance** on this area. The significant matters which require management attention include the compliance rate, at the time of testing, for completion of Declarations of Interest (DOI) across the Health Board is 29% for Band 8c or above with staff data uploaded to the system from ESR not updated regularly. Monitoring and reporting arrangements were not adequate to ensure reliability of the data and compliance with the Policy.

Procurement: Contract Management and Single Tender Waivers - We issued **reasonable assurance** on this area. Matters requiring management attention include evidencing a formalised performance monitoring process for all the contracts reviewed and reasons for approval of single tender waivers sometimes include stipulations for future requests and we were unable to confirm if these are actioned.

Integrated Service Boards (ISB) Governance - We issued **limited assurance** on this area. We noted that ISB Terms of Reference were not consistent across Areas; no evidence of Health Board Executive level scrutiny or oversight of ISBs; Health Board Committees do not receive updates from ISBs; and delegated authority regarding ISB participation is not stated in Health Board Standing Order and Financial Instructions or the Scheme of Delegation.

Targeted Intervention (TI) - We issued **reasonable assurance** on this area. We found that Terms of Reference underpinning the TI governance arrangements and associated housekeeping arrangements need review and that the Health Board ensures the financial framework is developed in line with recent Welsh Government correspondence.

Cluster working - Governance - We issued **reasonable assurance** with Terms of Reference needing review and update, meeting actions are not tracked and updated and inconsistent approach to risk management. We also identified areas of good practice for sharing across the Clusters.

Risk Management – We issued **reasonable assurance** for this review with inconsistency in risk identification on directorate/divisional risk registers when considering the impact of risks within specific areas; a number of fields that were not complete and risks were labelled as the wrong tier; a need to revisit the Research & Development risk to ensure it is reflective of all risks facing the Health Board plus risks associated with the North Wales Medical and Health Sciences School not being managed in line with the Health Board Strategy/Policy. 'Never Events' are risks that should not occur – there has been an increase in 2021/22 but the live risk is managed at Tier 2 which requires review.

Impact Assessments – We issued **reasonable assurance** on this area. Whilst there is some guidance in place for completion of key impact assessments, there is no process to ensure impact assessments are completed correctly.

Secondary Care – Ysbyty Glan Clwyd – This review was undertaken following several changes within the Hospital Management Team over the last year and a new management team in place at the time of review. Our review identified a lack of effective oversight and monitoring of the Quality Governance Review recommendations and actions; ineffective governance arrangements across the site; and challenges in delivering agreed savings – We issued **assurance not applicable** for this review.

Strategic Planning, Performance Management & Reporting

We have undertaken one review in this area.

Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists - We issued **limited assurance** on this area. We identified that the outpatient's governance spreadsheet needed tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Evidence from the risk stratification waiting list shows that patients within Orthopaedics and Urology as being overdue within the "Risk Strat/Reprioritised Status" section.

Financial Governance and Management

We have undertaken four reviews in this area.

Contingency: Security Invoice Review – No recommendations were made relating to this review, however we did identify areas for management to address including the need to remind all officers of the 'No PO No Pay' principle. We issued **assurance not applicable** for this review.

Financial Management, Reporting and Budgetary Control - We issued **reasonable assurance** on this area. We identified the need for management to ensure segregation of duties when completing virements and their timely completion.

Decommission of Ysbyty Enfys Temporary Hospitals - No recommendations were made relating to this review however we noted considerations for the future, including the need for clear communication between Executive Team and Project Team; Ensure projects have a clear Strategy/Plan to safeguard objectives are being met; Ensure robust governance arrangements in place at the outset; and ensure reporting lines and requirements are clear from the project onset. We issued **assurance not applicable** for this review.

Temporary Hospitals: Follow-up of KPMG recommendations – We followed up the implementation of the eight agreed recommendations presented to the Audit Committee and noted that three of the eight recommendations are considered implemented with the remaining five considered partially implemented. We issued **assurance not applicable** for this review.

Quality & Safety

We have undertaken five reviews in this area.

HASCAS & Ockenden external reports – Recommendation progress and reporting: Briefing Paper 1 – We reviewed the evidence supporting the closure of recommendations R14 (HASCAS) Care Advance Directives and R15 (HASCAS) Evidence Based Practice and noted that both were partially complete. We issued **assurance not applicable** for this review.

HASCAS & Ockenden external reports – Recommendation progress and reporting: Workforce Briefing Paper 2 – Ockenden R2 Workforce Development; R4a Staff Engagement Operational; R4b&c Staff Surveys Operational; R4d Clinical Engagement Operational; and R13 Culture Change where we noted that all remain 'in progress' towards completion. We issued **assurance not applicable** for this review.

Follow up of previous Healthcare Inspectorate Wales reports - We reviewed the evidence for the closure of each specific recommendation for the Mental Health and Learning Disabilities Division in 2020/21. We found that twenty-eight actions have evidence to confirm implementation. One action relating to record keeping arrangements remains outstanding and requires management attention. Five actions relating to Care and Treatment Plan audits, staff training, and recruitment are partially implemented, with further work required to complete these. We issued **assurance not applicable** for this review.

Clinical Audit - We have issued **limited assurance** in this area. We found no evidence that the appropriate information has been reviewed to ensure the Clinical Audit Plan is risk focused i.e. incidents, complaints, never events. There is no formal risk assessment to support the rationale for Tier 2 audits and timelines for completion and returns of Welsh Government National clinical audit proformas A and B are generally poor and not being met, including the non-completion and submission of forms.

Learning Lessons - We have issued **reasonable assurance** on this area. The review identified a variation in the documentation of lessons learned and how these are shared across the Health Board and a lack of assurance to the Quality, Safety and Experience Committee on the outcomes of lessons learned and if these have made a difference across the Health Board.

Information Governance & Security

We have undertaken one review in this area.

Network and Information Systems (NIS) Directive – We have issued **reasonable assurance** on this area. An appropriate process was in place to complete the Cyber Assessment Framework (CAF) and we noted areas of good practice concerning overall cyber security governance. We did note areas for refinement and further development. We also found no retention

of evidence to support the responses as part of the CAF process and that the funding implications for the improvement action plan have not yet been fully defined.

Operational Service and Functional Management

We have undertaken three reviews in this area.

Maternity Cross-border arrangements - We have issued **reasonable assurance** on this area. We identified that management needed to confirm the legal rights of expectant mothers requesting to birth in England and needed to review the robustness of application review and appeal process.

Business Continuity Plans – We have issued **limited assurance** on this area. The Business Continuity Group have only met three times in two years and attendance to the Working Group indicates only one of the meetings in the last two years was quorate. Fundamentally, there is a lack of local engagement encompassing development of local plans, training, updating and testing plans already in place.

On-Call arrangements - We have issued **limited assurance** for this review. There was a lack of guidance in place for staff, with the majority of staff surveyed not taking compensatory rest periods, impacting on staff wellbeing and possibly patient safety.

Workforce Management

We have undertaken five reviews in this area.

Upholding Professional Standards in Wales – Whilst the review was assigned **reasonable assurance**, we identified that the Designated Board Member (DBM) did not write/present reports to Board (required under Para.1.16) for exclusions over 6 months. DBM does not receive reports from the Case Manager (required under Para. 1.18) and the Scheme of Reservation and Delegation has not been amended to record UPSW requirements.

Nursing Roster Management: Introduction of e-timesheets for Agency staff - We have issued **limited assurance** in this area. We identified that most agency staff timesheets are not being submitted by agencies within 48 hours, as required to allow time to be reviewed for accuracy prior to payment. Shifts of over 12 hours require a one hour break, this has not been applied within the Health Roster Bank Staff system to a number of shifts of 12 hours or more, which is resulting in incorrect pay to agencies and increased costs to the Health Board.

Voluntary Early Release Scheme (VERS) - We have issued **reasonable assurance** in this area. The Health Board enhanced some elements of the Model Scheme which had a positive impact on the expected control and was overall well controlled, particularly by Workforce & OD. However, the narrative to support individual applications was limited and did not, in our view, provide adequate detail to capture and mitigate the risks from the

loss of such senior staff during a period of substantial change and operational challenge for the Health Board.

Establishment control – Leaver management - We have issued **limited assurance** on this area. The significant matter that requires management attention include holding operational managers to account for non-compliance with Health Board procedures, particularly in ensuring submission of termination forms in a timely manner. The Health Board is data rich and information provided to us as part of this review should be included in workforce related reports to all Divisions and Directorates, drawing attention to their poor leaver management, where it applies.

Recruitment – Employment of medical locum doctors - We have issued **reasonable assurance** on this area. The matters requiring management attention include justification notes to show reason for the request or any additional useful information were unavailable for some requests and do not provide useful information for others. We could not establish formal process in place to monitor contract performance and were unable to determine how information received from the company is being utilised to monitor performance or alternatively bring costs down.

Capital & Estates Management

This year we have completed three reviews in this area.

Waste Management – We have issued **reasonable assurance** for this review. There was non-compliance with waste management procedures and regular audits have not been undertaken due to Covid-19.

Statutory Compliance: Asbestos Management – We have issued **reasonable assurance** for this review. We were unable to determine if contractors are being provided with the necessary information and instruction coupled with asbestos Awareness Training compliance for estates staff is low.

Capital Funded Systems - We have issued **substantial assurance** on this area with the only matter noted requiring management attention concerning ensuring divisions/core programmes comply with requirement to rank submissions.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit

committee meetings and observe the quality and rigour around these processes.

For the second year in a row, due to the impact of COVID-19, we are aware that it has been more difficult than usual for NHS organisations to implement recommendations to the timescales they had originally agreed. In addition, we also recognise that for new recommendations it may be more difficult to be precise on when exactly actions can be implemented by. However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

Going forward, given that it is very likely that the number of outstanding recommendations will have grown during the course of the pandemic, audit committees will need to reflect on how best they will seek to address this position.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

The Health Board's recommendation tracking process continued during 2021/22, but the pandemic effected the ability of management to take forward recommendations in some areas. Where this has happened, we have scheduled a follow up audit to align with the revised timeline. These reviews are reported in section 5.7.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-

19 on this year's (and to an extent last year's) programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2021/22 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2021/22.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have

an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Health Board in conformance with the Public Sector Internal Audit Standards for 2021/22.

Our conformance statement for 2021/22 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2021/22 which will be reported formally in the Summer of 2022; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2021/22 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will

cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales;
- Welsh Health Specialised Services Committee; and
- Emergency Ambulance Services Committee.

Please note that, in response to COVID-19, we have altered our approach this year and undertaken additional testing on a number of the national NWSSP run systems and produced separate reports for each NHS Wales organisation where appropriate.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	The purpose of the audit review was to evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Procure to Pay (P2P) service.
Payroll	Reasonable	The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.
Primary Care Services – Medical (GMS), Pharmaceutical (GPS),	Substantial	The overall objective of the review was to evaluate and determine the

Dental (GDS), and Ophthalmic (GOS) Services		adequacy of controls in place to administer timely and accurate payments to primary care contractors

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Comments
Welsh Radiology Information System	Reasonable	-
Data Centre Transition	Substantial	-
Data Analytics (Information)	Reasonable	-
System Development	Reasonable	-
GP System Procurement Project	Substantial	-

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Comments
WHSSC – Risk management	Reasonable	-

Audit	Opinion	Comments
WHSSC – Cancer and blood services	Substantial	-
WHSSC – All Wales Positron Emission Tomography (PET) Service	Reasonable	-
EASC – Governance arrangements	Reasonable	-

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported, but are reflected within this Annual Report, will be reported alongside audits from the 2022/23 operational audit plan.

The audit plan approved by the Committee in April 2021 contained 31 planned reviews. Changes have been made to the plan with five audits added and six deferred/cancelled. All these changes have been reported to, and approved by, the Audit Committee. As a result, we have delivered 30 reviews.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22	G	March 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2021/22	G	100% (30/30)	100%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%
Report turnaround: time taken for management response to discussion & draft report [20 working days]	G	70%	80%	v>20%	10%<v<20 %	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%

Key: v = percentage variance from target performance

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 30 audit reviews were reported during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings

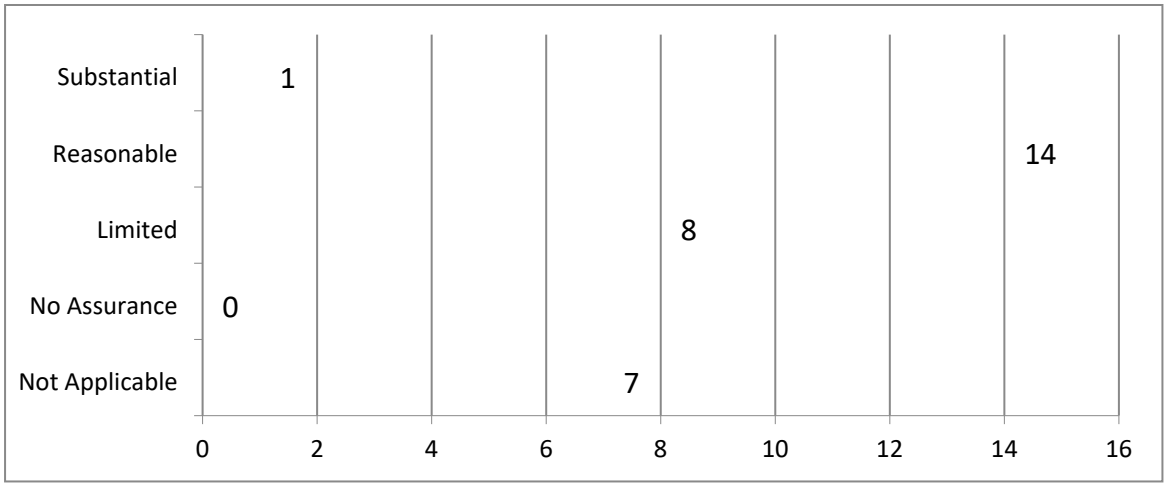


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW, WHSSC or EASC.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of COVID-19 was the reason for the deferral or cancellation and in other cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Capital Funded Systems	To provide assurance that processes for the allocation and risk assessment of Discretionary Capital are operating effectively.

5.3 Reasonable Assurance (Yellow)

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Statutory Compliance – Asbestos Management	To review compliance with the Control of Asbestos Regulations 2006 and associated Health Board policy.
Upholding Professional Standards in Wales	To review compliance with Circular M&D(W) 3/2015, Upholding Professional Standards in Wales (UPSW), which outlines the disciplinary procedure for Medical & Dental staff.
Maternity Cross - Border Arrangements	To determine the robustness of controls in place for managing cross-border maternity activity.
Procurement: Contract Management and Single Tender Waivers	To evaluate whether the Health Board is complying with Standing Financial Instructions and procedures concerning contract management, and the use of single tender and single quotation actions.
Targeted intervention	To ensure the Welsh Government issued Targeted Intervention (TI) Improvement Framework BCUHB requirements are complied with.
Learning Lessons	To identify how lessons learned from incidents, concerns and complaints are documented, evidenced and shared across the Health Board to minimise the risk of repeat events.
Voluntary Early Release Scheme (VERS)	To establish that the Health Board complied with the 2021 scheme is compliant with the VERS process.
Financial Management, Reporting and Budgetary Control	To provide assurance that budgetary control and financial reporting processes are operating effectively.

Review Title	Objective
Network and Information Systems (NIS) Directive	To review arrangements in place for the implementation of the NIS Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.
Cluster working - Governance	To establish the robustness of governance arrangements in place for a sample of Primary Care Clusters.
Recruitment – Employment of medical locum doctors	To ensure compliance with the Health Board standard operating procedure *Medical Agency Locum Appointments*.
Waste Management	To assess the Health Board's compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.
Impact Assessments	To determine the robustness of controls in place for the management and completion of Impact Assessments and external consultation. We will review a sample of approved BCUHB projects, strategies, or developments and consider the extent to which practice complies with relevant policies and legislation.
Risk Management	To ascertain how effectively the Risk Management Strategy and Policy is embedded in the Health Board.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Establishment Control: Leaver Management	To review the adequacy of the leaver management process within the Health Board. This includes the actions taken by management

Review Title	Objective
	and the oversight of the process by workforce & OD.
Standards of Business Conduct	To ensure processes are in place to comply with Standing Orders (Order 8): Values and Standards of Behaviour.
Integrated Service Boards Governance	To establish the role, function, and governance arrangements for Integrated Service Boards (ISBs).
Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists	To assess the Welsh Government initiated tranche 'patient' validation exercise and more broadly, the prioritisation of waiting lists for planned care and removal of patients from the waiting lists.
Nursing Roster Management: Introduction of e-timesheets for Agency staff	To assess the implementation and effectiveness of the new arrangements for agency e-timesheets.
Clinical Audit	To evaluate and determine the adequacy of the systems and controls in place for the planning and completion of clinical audits.
On-Call arrangements	To review the adequacy of on-call arrangements, reviewing the processes in place to ensure staff receive the relevant payments and compensatory rest periods.
Business Continuity Plans	To assess the status of Business Continuity Plans and sample a number of areas to ascertain their effectiveness in accordance with Health Board policies/procedures.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the

nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Security Invoice Review	To ensure adequate controls were in place to ensure payments of invoices from the external security contractor were made in full compliance of the Standing Financial Instructions and operational procedures.
HASCAS & Ockenden external reports: Recommendation progress and reporting	To review of evidence to support the progress/ closure for recommendations 14 & 15 of HASCAS.
Secondary Care Division – Ysbyty Glan Clwyd	To review the management arrangements within Ysbyty Glan Clwyd for ensuring effective governance and stewardship, including corporate and financial governance arrangements.
Follow up - Progress against Healthcare Inspectorate Wales (HIW) recommendations: Mental Health and Learning Disabilities	To provide assurance to the Board that there is sufficient evidence to support closure of Health Inspectorate Wales (HIW) reports recommendations relating to Mental Health and Learning Disabilities.
Temporary Hospitals: Follow up of KPMG recommendations	To provide assurance as to the current status of the eight recommendations arising from the KPMG report and as reported to Audit Committee.
HASCAS & Ockenden external reports: Recommendation progress and reporting - Workforce	To review of evidence to support the progress/ closure for Ockenden recommendations 2c, 4a, b, c, d and HASCAS 13, 14 & 15 .
Decommission of Ysbyty Enfys Temporary Hospitals	To provide a post contract cost audit exercise to be performed as part of project closure.

5.7 Audits not undertaken

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for deferment
Digital Strategy	Executive Director advised that it would be appropriate to defer to quarter 1 2022/23 to allow the implementation of the plan to become embedded.
Unscheduled Care	Direct impact on operational services as the impact of COVID-19 continued.
Transformation of services	Direct impact on operational services as the impact of COVID-19 continued.
Preparedness for Climate Change/Decarbonisation	Submission timeline set by Welsh Government for NHS Wales organisations is March 2022 and therefore any review would not commence until April 2022 at the earliest.
Value Based Healthcare	Executive Director advised that it would be appropriate to defer to 2022/23 as the team was still being recruited to.
Governance Structure	The implementation of the new operating model has not progressed in this financial year and therefore deferred to 2022/23.

In addition, at the time of this annual report there were no reviews that were 'work in progress'.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2021/22 plan.

Dave Harries CMIIA QiCA
Pennaeth yr Archwiliad Mewnol/Head of Internal Audit

Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

31st May 2022

Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk

	based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.

2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition, audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - Quarter 4 2021/22
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery Acting Associate Director of Quality
Awdur yr Adroddiad Report Author:	Claims Lead Manager and Claims Managers
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter 4 of 2021/22 (over £50,000)

Argymhelliad / Recommendation:

The Committee is asked to receive this report for assurance.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

The attached report sets out total payment information for any claims against the Health Board with a spend of over £50,000 closed during Quarter 4 (Jan - March 2022) of the 2021/22 financial year. This report formally summarises to the Audit Committee, the authorities given by the Health Board's Claims Managers, Directors Executive Team and Board.

This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.

The report is presented in two parts – one part in public containing summary information and a more detailed report for the private session which includes additional information that may be patient/staff identifiable.

Cefndir / Background:

All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).

The Health Board employs a team of Claims Managers who sit within the Quality Directorate. These legally trained staff were recruited to strengthen the management of claims. Clinical negligence and personal injury claims are managed by the Health Board on the basis of legal advice provided by the Legal and Risk Services Department of NHS Wales Shared Services Partnership. A clear, tightly defined national process is in place

overseen by the Welsh Risk Pool. The Welsh Risk Pool will reimburse the Health Board for all losses incurred above an excess of £25,000 on a case by case basis.

To ensure that learning and improvement is commenced and implemented at the earliest possible stage, the Welsh Risk Pool amended its reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case from 1 October 2019. The WRP procedures require a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Should the Audit Committee require it, there is a learning document available for the cases listed within the schedule attached.

In all cases, claims have been managed by the Claims Managers within the Quality Directorate who are all legally trained. All claims have been managed with the support and involvement of the Legal and Risk Services Department of NHS Wales Shared Services Partnership (NWSSP) and evidence of case management and learning has been, or will be, submitted to the Welsh Risk Pool.

The Quality, Safety and Experience Committee receives a separate quarterly Patient Safety Report to provide assurance on the learning and improvement following claims. This report to the Audit Committee provides assurance on the correct authorisation of payments as shown on the attached schedule for claims over £50,000.

Additionally, the Audit Committee is reminded that an annual internal audit of claims management is also undertaken which provides additional assurance on systems and process. The audit for 2020/21 has been completed and the process given **Substantial Assurance** with no recommendations made.

Asesiad / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – The Welsh Risk Pool process is briefly outlined above.

Dadansoddiad Risk / Risk Analysis – The rising cost of healthcare litigation is a risk for the Health Board and wider NHS. For the purpose of this paper, there is no risk regarding proper process and strong checks and validations are in place internally and externally to ensure and assure compliance.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – The Health Board remains in compliance with the Welsh Risk Pool standards.

Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report

Appendix 1 - Schedule of closed claims and financial value for quarter four of 2021/22 (over £50,000)

Ref	Type	Region	Specialty	Incident Date	Total (Payment summary)
CLA20-4720	Clinical Negligence	BCUHB West	Adult Community Mental Health Services	05/10/2019	£62,030.00
W16-2333	Clinical Negligence	BCUHB West	Appointments	22/12/2014	£280,327.73
CLA17-2742	Clinical Negligence	BCUHB Central	Emergency Department (Secondary)	03/01/2014	£224,247.91
CLA17-2814	Clinical Negligence	BCUHB West	Gynae Surgery (Secondary)	11/02/2017	£98,379.88
CLA17-3202	Clinical Negligence	BCUHB West	Gynae Surgery (Secondary)	30/03/2012	£113,739.82
CLA16-2500	Clinical Negligence	BCUHB East	Adult Acute Mental Health Services	13/02/2016	£1,096,931.83
C18-3406	Clinical Negligence	BCUHB Central	Emergency Department (Secondary)	24/12/2015	£65,293.50
C19-3953	Clinical Negligence	BCUHB Central	Vascular Surgery (Secondary)	08/11/2012	£162,400.00
CLA17-2911	Clinical Negligence	BCUHB West	Emergency Department (Secondary)	24/08/2016	£247,777.60
W14-1479	Clinical Negligence	BCUHB West	Dermatology (Area)	01/05/2012	£473,557.47
E15-1801	Clinical Negligence	BCUHB East	Obstetrics (Secondary)	01/02/2012	£91,993.10
C20-4913	Clinical Negligence	BCUHB Central	General Surgery (Secondary)	26/03/2016	£78,971.11
C17-3065	Clinical Negligence	BCUHB Central	Gastroenterology (Secondary)	01/08/2015	£181,541.17
CLA17-3081	Clinical Negligence	BCUHB West	General Surgery (Secondary)	20/06/2017	£85,630.67
C13-1100	Clinical Negligence	BCUHB Central	Emergency Department (Secondary)	06/01/2013	£713,824.22
CLA2396	Clinical Negligence	BCUHB Central	Gynae Surgery (Secondary)	30/12/2015	£91,168.26
ZG-CLA16-2452	Clinical Negligence	BCUHB East	Gynae Surgery (Secondary)	30/03/2016	£221,222.46
CLA17-2823	Clinical Negligence	BCUHB West	Midwife Episodes (Secondary)	13/08/2015	£64,414.50
CLA17-2735	Clinical Negligence	BCUHB Central	Urology (Secondary)	19/02/2013	£52,259.86
					£4,405,711.09

Report title:	Draft Risk Management Strategy		
Report to:	Audit Committee		
Date of Meeting:	Thursday, 30 June 2022	Agenda Item number:	
Executive Summary:	The 2022/2025 strategy is submitted to the Audit Committee for consultation ahead of its consideration by the Board in July This follows a series of consultation events including a review of the strategy and Board Assurance Framework highlights at the Board Workshop on the 17th of June 2022		
Recommendations:	The Audit Committee is asked to: • Note and endorse the objectives of the risk management strategy • Note and endorse the Risk Management Strategy for Board Approval in July 2022		
Executive Lead:	Board Secretary		
Report Author:	Molly Marcu, Interim Board Secretary		
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒

Assurance level:	Significant ☐	Acceptable ☒	Partial ☐	No Assurance ☐
	High level of confidence/evidence in delivery of existing mechanisms / objectives	General confidence/evidence in delivery of existing mechanisms / objectives	Some confidence/evidence in delivery of existing mechanisms / objectives	No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Not applicable

Link to Strategic Objective(s):	ALL
Regulatory and legal implications	Alignment to regulatory requirements associated with delivery of patient care as well as a safe working environment under the Health and Safety at Work Act
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below**	**Y**
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	(summarise risks here and provide further detail) (crynodeb o'r risgiau a rhagor o fanylion yma)

Financial implications as a result of implementing the recommendations	Risk Management training will be required as part of the process of enhancing the risk maturity of the organisation
Workforce implications as a result of implementing the recommendations	Not applicable
Feedback, response, and follow up summary following consultation	Feedback received from Executive team, QSE Chair, PFIG Chair
Links to BAF risks: (or links to the Corporate Risk Register)	All
Reason for submission of report to confidential board (where relevant)	Not applicable Amherthnasol
Next Steps: • Following consultation with the Audit Committee the strategy will be submitted to the Board in July • The Risk Management policy will also be reviewed to ensure it is aligned to the strategy and submitted to the Audit Committee in September 2022	
List of Appendices: Risk Management Strategy, Appendix 1	

Risk Management Strategy

2022 - 2025

Document Reference No.	V.8
Target audience	Health Board Wide
Author	TBC
Group responsible for developing document	Health Board
Status	Draft
Authorised/Ratified By	Health Board
Authorised/Ratified On	TBC
Review Date	TBC
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	TBC

Contents

1. INTRODUCTION

1.1. The Betsi Cadwaladar Health Board is committed to providing high quality patient services in an environment where patient and safety is paramount. However healthcare provision has an inherent level of risk that cannot always be eliminated.

1.2. The Health Board Risk Management Strategy provides a framework for the robust identification, assessment and management of risks to the delivery of strategy and of high quality healthcare by enabling staff to:

1.2.1. Identify actual or potential risks

1.2.2. determine how best to treat them

1.2.3. apply the treatment

1.2.4. monitor the effectiveness of that treatment while supporting the safe development of clinical care and maintaining continuity of service delivery.

1.3. Every member of staff is responsible for effective risk management.

1.4. The Health Board promotes a just, compassionate responsible culture that fosters learning, improvement, and accountability. It intends all staff to be able to raise issues of concern and be listened to.

1.5. The Health Board recognises that complete risk control/avoidance is impossible, but risks can be minimised by making sound judgements from a range of fully identified options.

1.6. The Health Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated and mitigated to an acceptable level in a timely manner wherever possible.

2. PURPOSE

2.1. The Risk Management Strategy is a framework for the continued development of the risk management process, building on principles and plans linked to the Board Assurance Framework, the Risk Register and meeting requirements of Regulators such as Health Inspectorate Wales, Health and Safety Executive, along with national priorities.

2.2. The Risk Management Strategy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the “Ward to Board” accountability and devolved governance structure.

3. STRATEGIC OBJECTIVES

3.1. This strategy supports the delivery of the Health Board’s Living Healthy, Staying Well, strategic aims, agreed by the Board in July 2022, which are outlined below:

- 3.1.1. Improve physical, emotional and mental health and well-being for all
- 3.1.2. Target our resources to people who have the greatest needs and reduce inequalities Support children to have the best start in life
- 3.1.3. Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being
- 3.1.4. Improve the safety and quality of all services
- 3.1.5. Respect people and their dignity
- 3.1.6. Listen to people and learn from their experiences

3.2. The Health Board Strategic aims will be delivered through the following enabling strategies:

- 3.2.1. Clinical Service Strategy
- 3.2.2. People Strategy
- 3.2.3. Estates Strategy
- 3.2.4. Digital Strategy
- 3.2.5. Quality Improvement Strategy
- 3.2.6. Risk Management Strategy

3.3. As part of the delivery of these strategies appropriate mitigations will be put in place to ensure significant risks are proactively identified and mitigated as part of their delivery.

3.4. The delivery of this Risk Management Strategy will enable the embedding of an infrastructure that enables robust identification and management of risks that may prevent the achievement of Health Board objectives.

3.5. The Board will approve and monitor the delivery of these strategies and mitigations of associated risks through its Committees.

3.6. The work plan of each Board committee will incorporate agenda items which will ensure risks to the delivery of our strategies are identified and managed as appropriate.

3.7. Section 8 provides more detail on Board Committees and their specific responsibilities.

4. OBJECTIVES OF THE RISK MANAGEMENT STRATEGY

4.1. The objectives of the Risk management strategy are:

*4.1.1. To **proactively identify**, manage and monitor significant risks that the Health Board is exposed to during the delivery of patient care, as well as its wider objectives*

4.1.2. To ensure that risks that can materially impact on the Health Board's key statutory objectives are proactively identified, assessed and managed

4.1.3. To enhance the risk maturity of the Health Board from Risk Aware to Risk Enabled

4.2. The Strategic Objectives of the Health Board evidence the Board prioritising patient safety, quality of care, staff wellbeing and development, and achievement of national standards.

4.3. The Health Board Performance and Risk Management Frameworks will be integrated, to ensure risks related to performance indicators are identified, treated and monitored to minimise the impact on quality. ***Performance indicators will be integrated with the Board Assurance Framework.***

4.4. At an operational level, the Health Board will apply ***a proactive risk management approach to identify risk through analysis of performance data and an Early Warning Trigger Tool***, described in detail in section 13.

4.5. A quality impact assessment tool will be used to identify possible risks to quality and safety arising from service re-design savings initiatives or variations in service delivery, such as bed pressures.

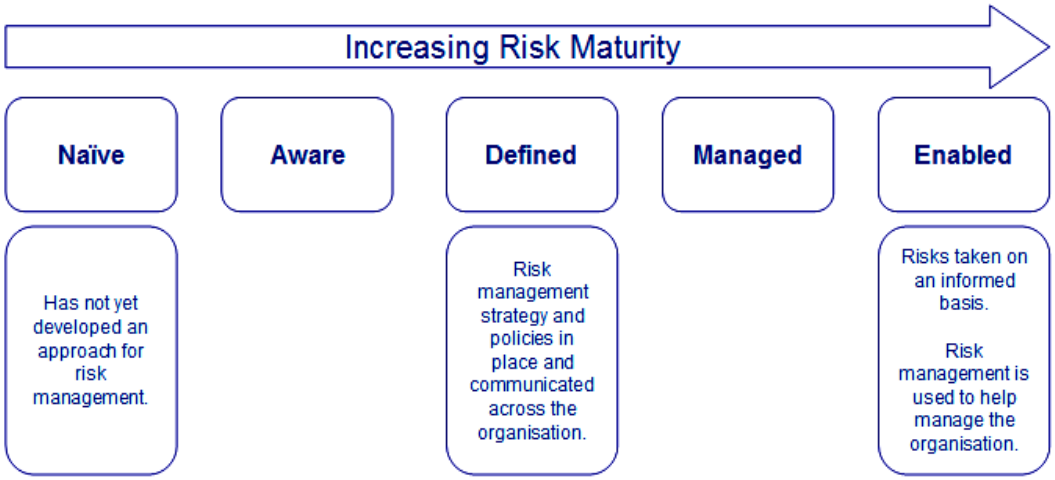
4.6. Themes from a number of quality and safety indicators including patient safety incidents, mortality reviews, complaints, and claims will be used to identify risks to quality, and trends used to assess whether previously identified risks are managed appropriately.

4.7. The Health Board will also use learning from experience as a risk mitigation approach.

4.8. This is covered in more detail in section 12.5.

Objective 3: *To increase the risk maturity of the Health Board from Risk Aware to Risk Enabled*

Figure 2: Risk Maturity scale



4.9. Figure 2 above shows the different levels of risk maturity that the Health Board can achieve as risk managements becomes embedded in the organisation.

4.10. The Health Board intends to enhance the risk maturity of the organisation to 'Risk Defined by March 2024, and achieve 'Risk Enabled' status by 2025.

4.11. The Board will review its risk maturity, appetite and Board Assurance Framework annually at the end of each financial year.

4.12. The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Audit Committee will monitor the implementation of any recommendations arising from this audit.

5. RISK APPETITE

5.1. Risk appetite is the total level of risk exposure, or potential adverse impact, that the Health Board is willing to accept in pursuit of its objectives.

5.2. The pursuit of one objective may hinder the achievement of another and this will impact upon the associated risk appetite. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy.

5.3. The Board recognises the importance of a robust and consistent approach to determining risk appetite to ensure:

5.3.1. The organisation's collective appetite for risk and the reasons for it are widely known to avoid erratic risk taking, or an overly cautious approach which may stifle growth and innovation.

5.3.2. Health Board Managers and senior leaders know the levels of risk that are legitimate for them to take, and opportunities appropriate to pursue, to ensure service improvements and patient outcomes are not adversely affected.

5.4. To value and compare the relative merits and weaknesses of different risks, the Health Board will determine the level of risk the organisation is willing to tolerate in different areas.

5.5. This will include deciding whether the Health Board will ***treat, tolerate, transfer or terminate a risk and what the organisation's 'target risk score' should be. Operating within risk tolerances gives the Board assurance that the Health Board will remain within its risk appetite and, as a result, achieve its objectives.***

5.6. The Health Board Executive Team will put systems in place to manage risk to an acceptable level within its agreed risk appetite levels. In setting such levels, the Health Board will take account of the degree of both and opportunity.

5.7. When risks are identified, the Executive Directors will recommend to the Board whether to tolerate or accept them. Executive Directors will provide on-going assurance to the

Board that existing controls are sufficient to mitigate risks to within the agreed tolerance levels, and will highlight where the cost of treating the risk is more expensive than the potential benefits to be realised.

5.8. Target risk ratings shall be set for all risks on the Datix Risk Management System. A target risk rating is the estimated residual risk following the application of reasonable mitigating controls.

5.9. The target risk rating is the lowest level of risk acceptable or tolerable for particular risks.

5.10. Some risks tolerance levels will require the approval of the Board or committees where relevant, particularly where the application of controls is restricted by external factors. Where this is the case, it will be outlined clearly in the BAF cover report, which is expanded on in section 6.

5.11. Risks that have reached the agreed target rating will also be treated as tolerated risks.

5.12. Risks should be accepted as tolerable only when the mitigation plan has been implemented as far as reasonably practical and there is assurance that controls are effective.

5.13. The Health Board regards risks that fall into the red ‘high’ category as significant and actions to control the risk must be taken immediately.

6. RISK APPETITE STATEMENT

6.1. The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

6.2. The Health Board is committed to ensuring a robust infrastructure to manage risks from ward to board level, and where risks crystallise, to evidencing improvements are put in place.

6.3. The Health Board's intention is to ***minimise*** the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks and maximise performance.

6.4. To deliver ***safe, quality*** services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to ***minimise*** risk to the greatest extent possible and promote patient well-being. Additionally, the Health Board seeks to ***minimise*** the harm to service users arising from their own actions and harm to others arising from the actions of service users.

6.5. The Health Board wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures consistent with the strategic direction set out in the Health Board Strategy, whilst respecting and abiding by its statutory obligations.

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Improve physical, emotional and mental health ***Failure to achieve 2022/23 savings target of £35m, resulting in a breach of our statutory financial duty*** and well-being for all.	OPEN	The Health Board recognises that in order to provide outstanding care and patient experience there may be a need to accept a short-term impact on quality outcomes to achieve longer term rewards and innovations for our patients.
SO2: *Target our resources to people who have the greatest needs and reduce inequalities*	OPEN	The Health Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Health Board is an employer of choice.
SO3 *Respect people and their dignity*	OPEN	The Health Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: *Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being*	SEEK	The Health Board recognises there may be an increased inherent risk faced with collaboration and partnerships but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.

SO5: *Improve the safety and quality of all services, whilst listening to people and learning from their experience*	SEEK	The Health Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: *Support children to have the best start in life*	OPEN	The Health Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

7. CORPORATE RISK REGISTER

7.1. The Corporate risk register (CRR) provides a framework for monitoring risks deemed signification to the delivery of corporate objectives set out within the annual plan.

7.2. The CRR is owned by the Risk Management Group, and will be subject to a bi-monthly review as a standing item, and risks with a current rating of 15 and above will be included.

7.3. Risks with a lower rating will be incorporated within divisional risk registers, and kept under review in order to ensure escalating risks are proactively identified.

7.4. The CRR will be reviewed regularly in order to ensure its completeness, alongside risks with a lower current risk rating.

7.5. A formal internal assessment of the CRR's completeness will be undertaken on a bi-annual basis and submitted to the Audit Committee for the purposes of providing assurance on :

7.5.1. The completeness of the clinical and corporate risk profile, when triangulated with significant issues for incorporation with the Annual Governance Statement

7.5.2. Whether any risks on the CRR require inclusion onto the Board Assurance Framework

7.5.3. Reviews undertaken to determine de-escalation of risks as well

7.5.4. Consideration has been given to significant risks arising from internal and external sources (as outlined in section 9 of this document)

7.6. As part of the process of monitoring the CRR, staff will be actively encouraged and empowered to raise any new or emerging risks as part of their day to day work, subject to independent verification by the lead Executive Director and Risk Management Team.

7.7. The CRR will be reviewed on the following frequency, within the Board and committee structure

Forum	**Frequency**	**Role/Purpose**
Risk Management Group	Bi-monthly	Assurance, and oversight of maintenance of document
Quality, Safety and Experience Committee	Bi-monthly	Assurance on the CRR in its capacity as the Risk Committee of the Board, taking into account assurances received from the work of the Risk Management Group
Audit Committee	Quarterly	Independent Scrutiny and Challenge of the risk management process
Performance, Finance and Information Governance Committee	Bi-monthly	Assurance and oversight of risks relevant to the Committee
Partnerships, People and Population Health Committee	Quarterly	Assurance and oversight of risks relevant to the Committee
Mental Health and Capacity Committee	Quarterly	Assurance and oversight of risks relevant to the Committee
Board	Annually	Year End assurance, taking into account detailed work undertaken by the Board's Committees

8. THE BOARD ASSURANCE FRAMEWORK (BAF)

8.1. An effective Board Assurance Framework gives the Board a simple comprehensive tool for effective and focused management of the principal risks to meeting its objectives.

8.2. It provides a structure for the evidence to support the Annual Governance Statement disclosure. It simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

8.3. The Board Assurance Framework provides the Board with a mechanism of identifying and assessing risks significant to the delivery of Health Board strategy, whilst evaluating the effectiveness of controls, and the monitoring of action plans.

8.4. The Board Assurance Framework (BAF) is based on six key elements:

8.4.1. Clearly defined principal objectives aligned to clear lines of responsibility and accountability.

8.4.2. Clearly defined principal risks with an assessment of potential impact and likelihood.

8.4.3. Key controls by which these risks are being and can be managed.

8.4.4. Quantification of the strengths and weaknesses of potential and actual assurances that the risks are being properly managed.

8.4.5. Reports identifying those risks are being reasonably managed and objectives being met, together with the identification of any gaps in assurances and in control

8.4.6. Action plans which ensure the delivery of objectives control of risk and improvements in assurances.

8.5. The BAF cover reports will be aligned to support assurances to support the Chief Executive's Annual Governance Statement Disclosure.

8.6. Specifically, BAF assurance reports to the Board will reflect:

8.6.1. New risks added since the last meeting

8.6.2. Changes in risk ratings

8.6.3. Updates on delivery of action plans, at points in which they fall due

8.6.4. Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.

8.6.5. Triangulation with any other items on the agenda, such as performance reports

8.6.6. Recommendations for remedial actions that require detailed board review

8.7. Lastly, the BAF reports will flag risks that require escalation to the Board in a timely manner.

8.8. The BAF will be refreshed annually considering :

8.8.1. Risks which may prevent the Health Board from achieving the Strategic Objectives will be set out in the Board Assurance Framework, and assessed annually.

8.8.2. At the end of each financial year, the Board will collectively review the BAF, to identify the risks significant to the delivery of the organisation's strategic objectives.

8.9. Further new risks proposed for inclusion on the Board Assurance Framework will be added following the agreement of the Board as they arise.

8.10. Each risk in the BAF will be scored using the Health Board's Risk Scoring Matrix, and monitored in accordance with the frequency set out.

8.11. The Board Assurance Framework will be reviewed quarterly by the Health Board.

9. RISK MANAGEMENT DUTIES

9.1. Chief Executive

9.1.1. As Accountable Officer of the Health Board, the Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the Health Board's objectives, whilst safeguarding public funds and assets

9.1.2. The Chief Executive will ensure that executive directors have appropriate access to annual training and education for risk management in healthcare to enable them to undertake their roles effectively.

9.1.3. The Chief Executive will ensure that there are robust arrangements for business continuity planning.

9.1.4. The Chief Executive is responsible for ensuring that the Health Board is administered prudently and economically and that resources are applied efficiently and effectively.

9.2. Executive Directors

9.2.1. The Executive Directors are accountable to the Chief Executive for all areas of risk and assurance in respect of areas in their remit, including the maintenance of live risk registers which are monitored regularly

9.2.2. Executive Directors are collectively accountable for risk management and ensuring risk management arrangements are embedded in their areas of responsibility, with specific roles outlined below:

9.3. Lead Director responsible for risk management

9.3.1. The Lead Director responsible for risk management has delegated overall strategic responsibility from the Chief Executive for the management of risk in the Health Board and is the Executive Lead Director for devising, implementing and embedding all risk processes throughout the organisation.

9.3.2. The Lead Director responsible for risk management will provide advice on risk management to the Executive Directors and Board, and will recommend the inclusion of risks on the Board Assurance Framework.

9.3.3. The Lead Director responsible for risk management will ensure the corporate risk register is reviewed monthly at the Risk Management Group, with remedial actions put in place to address non-compliance.

9.4. Board Secretary

9.4.1. As the Health Board lead for strategic risk, the Board Secretary is responsible for:

9.4.1.1. Drafting and refreshing the risk management strategy

9.4.1.2. Overseeing the process of implementing the strategy

9.4.1.3. Maintaining and updating the BAF, whilst ensuring timely submissions are made to the Board and Assurance Committees as appropriate

9.4.1.4. Ensuring the Annual Governance Statement requirements pertaining to risk management are met on an annual basis

9.5. Executive Director of Nursing

9.5.1. The Executive Director of Nursing will ensure nursing and allied healthcare staff comply with all safety and risk management procedures, providing

assurance on the management of risks related to their professional practice, liaising with professional bodies as required.

9.6. Executive Director of Finance

9.6.1. The Executive Director of Finance is also the Senior Information Risk Owner (SIRO) and has executive responsibility for the identification, scoping definition and implementation of an information security risk programme.

9.6.2. The SIRO oversees the development of an Information Risk policies and procedures; ensures that the Health Board's approach to information risk is effectively resourced and executed and provides a focal point for resolution of information risk issues.

9.6.3. The SIRO will act as an advocate for information risk on the Board and in internal discussions, and will provide written advice to the Accountable Officer on the content of the annual Governance Statement in regard to information risk.

9.6.4. The Executive Director of Finance has responsibility for ensuring that the Health Board operates within financial constraints and balances competing financial demands and overseeing the delivery of the internal audit plan and associated internal audit recommendations.

9.6.5. The Executive Director of Finance is accountable to the Board for the delivery of the financial plan and digital strategies, and for managing associated risk.

9.7. Executive Director of Workforce and Organisational Development

9.7.1. The Executive Director of Workforce and Organisational Development is responsible for ensuring risks deemed significant to the delivery of workforce objectives are met, with assurance reports feeding into the Workforce Assurance Committee, Board, and elsewhere as appropriate.

9.7.2. As Executive lead for Health and Safety, the Executive Director of Workforce and Organisational Development is responsible for ensuring the timely identification and mitigation of risks to Health and Safety

9.8. Executive Director of Integrated Clinical Services

9.8.1. The Executive Director of Integrated Clinical Services is responsible for ensuring the delivery safe and effective care whilst mitigating associated risks,

such as risks to delivery of targets being achieved. In discharging this duty the Executive Director of Integrated Clinical Services will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated.

9.9. Executive Director of Public Health

9.9.1. The Executive Director of Public Health is responsible for ensuring the delivery safe and effective care within Population Health, Mental Health, Women and Children's services whilst mitigating associated risks, such as risks to delivery of targets being achieved. In discharging this duty the Executive Director of Public Health will ensure a ***robust divisional accountability*** infrastructure is in place in order to provide assurance that risks are being appropriately mitigated

9.10. Independent Members

9.10.1. Independent Members (IMs) have an important role in risk management, seeking assurance on the effectiveness of procedures and controls through constructive challenge and holding the Executive Directors and Senior Management to account. The role of IMs is not to manage individual risks, but to satisfy themselves that the Health Board's risk management arrangements are robust and fit for purpose.

9.11. All Staff

9.11.1. All staff have a responsibility to:

9.11.1.1. Familiarise themselves with and comply with Health Board Risk Management Policy and processes

9.11.1.2. Attend appropriate risk management training deemed necessary to enable them to undertake their duties

9.11.1.3. Mitigate risks over which they have control in their daily work

9.11.1.4. Proactively escalate concerns in instances where gaps in risk management training are identified, as soon as reasonably possible to their line manager.

9.11.1.5. Report breaches of compliance as outlined within the risks management strategy, whether by others or by themselves

10. GOVERNANCE ARRANGEMENTS FOR RISK MANAGEMENT

10.1. Health Board

10.1.1. The role of the Board includes the identification, treatment and monitoring of risks signification to the delivery of the organisation's strategic objectives, which is aided by the use of a Board Assurance Framework (BAF).

10.1.2. The BAF document has been established by the Board and will be reviewed on a Bi-Monthly basis.

10.1.3. **The Executive Director Team will** retain operational ownership and maintenance of the BAF. Its key elements include:

10.1.3.1. Identification of the principal risks that may threaten the achievement of Board identified strategic objectives

10.1.3.2. Identifying the design of controls to manage these principal risks

10.1.3.3. Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk

10.1.3.4. Identifying assurances and are gaps in controls and / or assurances

10.1.3.5. Instigating corrective plans where gaps in control have been identified

10.1.3.6. Dynamic risk management including a well-founded risk register

10.1.4. The Board is responsible for monitoring the internal control arrangements in each financial year to support the Annual Governance Statement Disclosure declaration.

10.1.5. As part of the delivery of this strategy, the Board will:

10.1.5.1. Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner and monitored through the BAF and the Board agenda

10.1.5.2. Assess and evaluate the appropriateness of risk tolerance levels set out in the risk tolerance matrix and formally agree any amendments.

10.1.5.3. Monitor significant risks via the BAF, whilst receiving assurance from Board committees, on the implementation of mitigating actions

10.2. Board Committees

10.2.1. Each Committee of the Board has specific responsibility for seeking on going assurance on the effectiveness of the arrangements for managing key risks.

10.2.2. The Board will review the effectiveness of each Committee annually to support the review of the system of internal control.

10.2.3. Board Committees all have responsibility for elements of the risk management system, with the Audit Committee independently assessing its effectiveness

10.3. Audit Committee

10.3.1. The Audit Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The Committee will seek assurance that the Health Board's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.

10.3.2. Independent members of the Audit Committee will play a key role in the internal control assurance processes, by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Health Board risk register.

10.3.3. To aid this assurance, the Committee's work plan incorporates a review of the organisation's risk management processes, and associated risk registers, from divisional to corporate level on a cyclical basis, to gain assurance that systems in place are effective.

10.3.4. The Committee will monitor action plans associated with the delivery of this strategy.

10.3.5. The Audit Committee will provide assurance to the Board on the effectiveness of the system of internal control through:

10.3.5.1. Regular monitoring of significant corporate and strategic risks on behalf of the Board

10.3.5.2. Monitoring of the implementation of the internal audit plan, and of associated internal audit recommendations, requesting further assurance on the management of risks identified from audits with limited assurance opinion

10.3.5.3. Formally reviewing the system of internal control annually taking assurances from Board Committees on management of detailed risks.

10.4. Quality, Safety and Experience Committee

10.4.1. The Quality, Safety and Experience (QSE) Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy

10.4.2. As the Risk Committee of the Board, the QSE Committee will meet six times a year and will review significant risks with a Health Board wide impact and the BAF at each meeting

10.4.3. As part of its role the QSE Committee will seek detailed assurance reports on significant risk areas identified through the aggregation of incidents, complaints, never events and claims

10.4.4. The Committee will report to the Board via a Chair's assurance report, with specific assurance given on the action plans to mitigate risks, as well as independent sources of assurance where possible.

10.4.5. The QSE Committee will review risks with a residual rating of 15-25, ***with a particular focus on risks to patient safety, quality and patient experience,***

taking into account risks identified through clinical and internal audit processes

10.4.6. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will review and monitor progress against mitigation of key risks at each meeting on a bi-monthly basis.

10.4.7. As part of the implementation of this strategy the QSE Committee will:

10.4.7.1. Review assurances on learning and how it is embedded in divisions to manage risks. ***The Committee will regularly review recurring themes from incidents, complaints, Regulation 28 coroner reports as well as serious incidents***

10.4.7.2. Request detailed reports on the top strategic risks as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports

10.4.8. As part of its remit, the Committee has a responsibility to monitor the delivery of the Quality Improvement Strategy, Clinical Strategy and associated risks

10.5. Performance, Finance and Information Governance (PFIG) Committee

10.5.1. As part of the delivery of this strategy the Committee will:

10.5.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.5.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.5.1.3. Monitor the implementation of the:

- Digital Strategy
- Integrated Medium Term Plan
- Savings Plan
- Performance recovery plans and associated targets

10.5.2. And the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.5.3. The PFIG Committee will review risks with a residual rating of 15-25, with a particular focus on risks to performance, finance and information governance, taking into account risks identified through external and internal audit processes

10.6. Partnerships, People and Public Health (PPPH) Committee

10.6.1. As part of the delivery of this strategy the Committee will:

10.6.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.6.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.6.2. Monitor the implementation of the People Strategy, Living Healthy Staying Well, and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.6.3. The PPPH Committee will review risks with a residual rating of 15-25, with a particular focus on risks to Population Health, Transformation, people and partnerships, taking into account risks identified through external and internal audit processes

10.7. Mental Health Capacity Compliance Committee

10.7.1. As part of the delivery of this strategy the Committee will:

10.7.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.7.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.7.2. Monitor the implementation of key legislative requirements and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.7.3. The MHCC Committee will review risks with a residual rating of 15-25, with a particular focus on risks to Population Health, Transformation,

people and partnerships, taking into account risks identified through external and internal audit processes

10.8. Risk Management Group

10.8.1. The Risk Management Group (RMG) will maintain operational oversight of the risk management systems and process, whilst ensuring they are fit for purpose and embedded across all areas of the Health Board in line with this Risk Management Strategy.

10.8.2. The Group will also maintain oversight of risks and providing scrutiny and oversight of the full Corporate Risk Register prior to review by Board Committees. The Risk Management Group will report to the QSE Committee, providing assurance on arrangements put in place by senior managers to proactively identify and mitigate risk. The RMG will also perform the following functions:

10.8.2.1. Review, scrutinise and challenge the effectiveness of proposed or current mitigations, and actions pertaining to risk register reports, including new risks that have been approved by Executive Directors for inclusion on the CRR/Tier 1.

10.8.2.2. Undertake deep dives and `check and challenge` of risks on the CRR including those that have been approved for the CRR/Tier 1 as well as challenge any change in risk scores that have been approved by Executive Directors and advice appropriately.

10.8.2.3. Receive assurance reports from the Head of Risk Management triangulating risks from other sources (such as clinical audit, never events, serious incidents, internal and external audits) and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.

10.8.2.4. Review and scrutinise risk management performance reports, audits, the updated Risk Management Strategy and its associated procedural documents as well as any other risk management related reports and advise accordingly.

10.9. Executive Delivery Groups

10.9.1. The Executive Delivery Group Chair of the organisation have a duty to ensure a live processes ensure risks are identified proactively and robustly mitigated, escalating in a timely manner where appropriate.

10.9.2. The Executive Delivery Groups (EDGs) of the Health Board are:

- Population Health
- People and Culture
- Performance and Finance
- Quality

10.9.3. As part of the implement of this strategy, risk management will be a standing agenda item on the EDG agendas, and a record of appropriate action taken in relation to existing or new risks.

10.9.4. Each EDG Chair will ensure that a process is in place to ensure significant risks are escalated and mitigated in a timely and effective manner.

10.10. Local Quality, Safety and Governance Meetings

10.10.1. As part of the implementation of this strategy, all senior managers will put in place the necessary arrangements to maintain oversight of the proactive and effective management of risks through in place for good governance, quality, safety and effective risk management.

10.10.2. Senior managers will ensure monthly Quality and Safety or governance meetings are held, with a particular focus on monitoring and updating their risks, whilst enabling environment for bottom-up risk reporting with Services

and Departments under their remits routinely providing their risk register reports for review, scrutiny, assurance and oversight.

10.10.3. Through the implementation of this strategy senior managers will ensure a devolved accountability infrastructure is in place to maintain visibility of risks at all levels

10.11. Health and Safety Risks

10.11.1 Employers are required under the Management of Health and Safety at Work Regulations 1999, the Health and Safety at Work etc, Act 1974 and other pieces of legislation to protect their employees, and others, from harm.

10.11.2 Employers and employees thus have a duty of care to protect the health, safety and welfare of anyone who may be affected by their actions and/or omissions. Health and Safety risks, which arise within the context of occupational health and relation to assessment of hazards that could lead to the harm, injury, death or illness of a worker in a workplace.

10.11.3 Examples of Health and Safety risks include fall from height electrocution, water safety, confined spaces, construction, asbestos, COSHH, fire safety, slips, trips and falls , violence and aggression, work-related accidents and ill health.

11. APPROACH TO RISK

11.1. Risk Identification

11.1.1. The risk management process is outlined in detail within the Risk Management Policy.

11.1.2. As part of the implementation of this strategy, the Health Board will put in place proactive and reactive approaches to the identification of risks, primarily through the risk assessment processes which assess the potential to cause any of the following:

11.1.2.1. Injury

11.1.2.2. Complaint

11.1.2.3. Litigation

11.1.2.4. Damage to the environment or property

11.1.2.5. Failure to maintain services and/or the quality of services provided by the Health Board,

11.1.2.6. Failure to meet national and organisational targets loss of reputation and financial loss etc.

11.2. Sources of risk identification

11.2.1. There are internal and external sources of risk:

11.2.1.1. Internal risks are identified, in the course of strategic and business planning, adverse incidents, complaints, claims, noncompliance with statutory duties and guidance, enquiries and clinical/nonclinical hazards identified for any Health Board activities.

11.2.1.2. External sources of risk are identified in the course of risk alerts, hazard warnings and recommendations received by the Health Board from a recognised external source – e.g. information from the Medicines & Healthcare Products Regulatory Agency (MHRA), HIW, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE), inquiries and other bodies. These will be communicated immediately and applied as appropriate in the Health Board.

11.2.2. In implementing this strategy, the Health Board's goal is to ensure that the effect of any risk is reduced to an acceptable level or negated completely. In practice, this will be executed by using internal and/ or external advice to decide on the most appropriate options to treat risk and by sharing best practice and learning from other organisations.

11.2.3. Risk treatment (means of addressing risks) can be broken down into the following:

11.2.3.1. Avoid - some risks may only be managed by terminating the activity (i.e. avoiding the risk by not undertaking the activity that could lead to the risk occurring)

11.2.3.2. Control - preventative controls are measures currently in place when a risk is identified to control the risk i.e. directive controls or policies and processes, clear labelling of packages, checking a patient's identity before a procedure. If existing controls are shown not to be adequate, e.g. gaps are identified, an action plan should be produced to ensure the risk is mitigated with additional controls. Action plans will be approved initially by a division as per the risk reporting arrangements

11.2.3.3. Transfer - for some risks, the best method of control is to transfer them to a third party to reduce the exposure to the Health Board or because another organisation will manage the risks more effectively e.g. financial risks can sometimes be transferred by effecting insurance). However, this process needs to be carefully managed and internally validated to ensure the Health Board's exposure is minimised.

11.2.3.4. Tolerate - the exposure to the risk may be tolerable/accepted without any further controls.

11.2.4. In assessing any mitigating actions associated with a risk there should also be an assessment of the impact of such actions.

11.2.5. All managers have authority for risks in their areas of responsibility in line with their resources available to them to eliminate or control the risk. Where the manager does not have suitable or sufficient resources they should refer the issue to their line manager.

12. RISK MANAGEMENT PROCESS

12.1. The Risk Management process is summarised in figure 4 below, and incorporates a proactive and reactive approach.

12.2. Risk assessment is an iterative process and all risks will be periodically reviewed and re-assessed in view of contextual changes.

12.3. Re-assessment is undertaken proactively at intervals proportionate to the risk magnitude and risk appetite as well as reactively in response to anticipated or known changes.

12.4. The Health Board will explore its risk appetite for significant risks through a review of the Board Assurance Framework, Health Board risk register and evidence considered as to whether residual risks are acceptable or not.

12.5. All strategic risks will be reviewed on a bi-monthly basis by the Executive Directors who confirm their management through the content of the BAF in preparation for presentation to the Board.

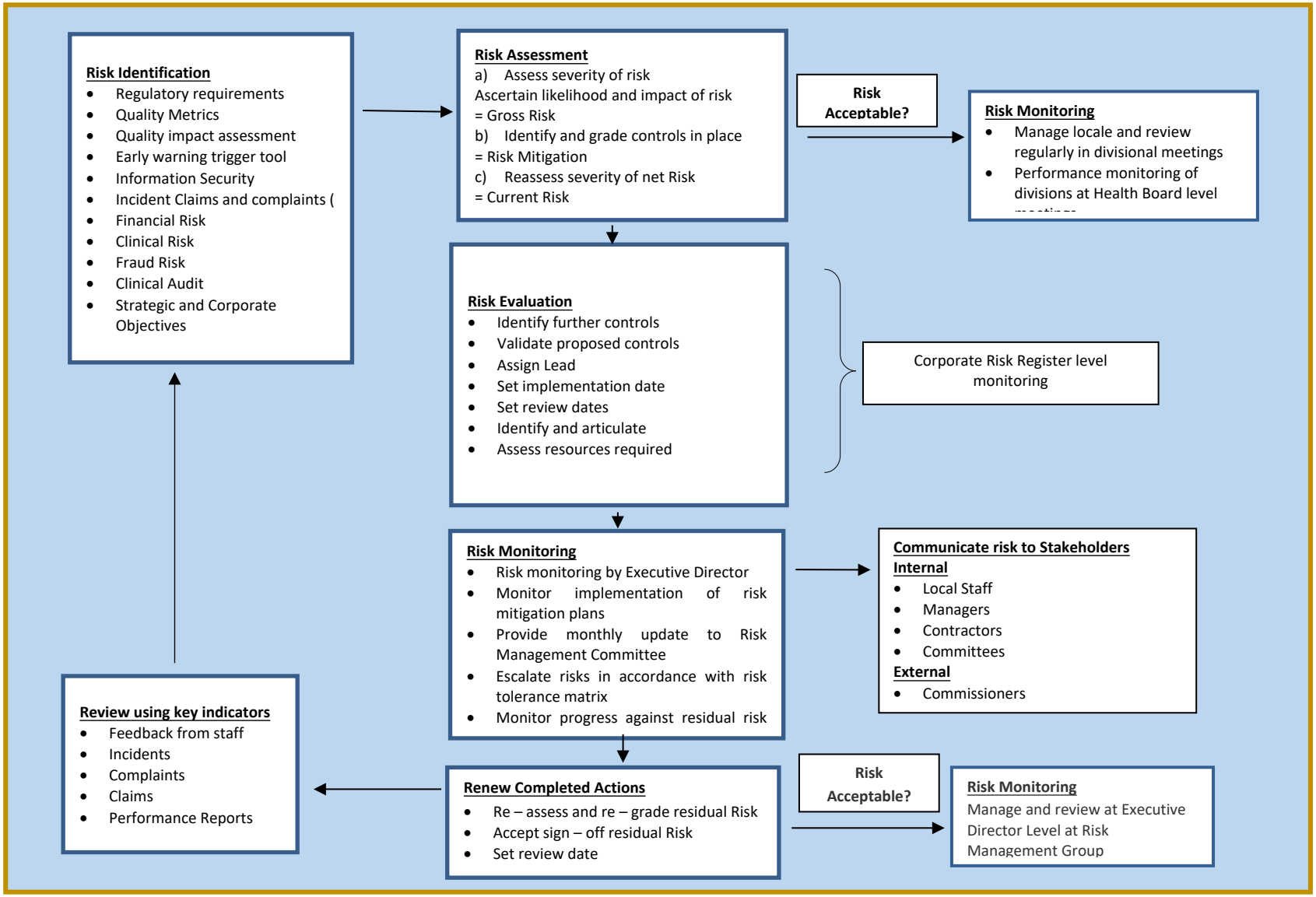
12.6. All moderate and significant risks (current risk score 9-25) will be reviewed by the Executive Directors who will confirm their approach to mitigation through the content of the Health Board risks register operationally at Health Board Management Board, and also the Risk Management Committee on an alternate basis in preparation to the Board for their consideration

12.7. All lower level risks (with a current risk score less than 9) are reviewed and managed locally by the Divisional management in their Governance meetings.

12.8. Risks which are not considered acceptable at a local level will be escalated as appropriate, and managed through strategic and operational change or transferred (e.g. by contracting out) leaving acceptable (and opportunity) risks.

12.9. Such risks are managed and mitigated through the Risk Management processes and retained risks are recorded and reviewed through the Health Board's risk registers.

Figure 4: Risk Management process



13. PROACTIVE RISK MANAGEMENT APPROACH

13.1. Internal inspections/reviews and assessments

13.2. Risks will be identified, assessed and mitigated through internal inspections or reviews, e.g.:

13.2.1. Statutory/Regulatory gap analysis or internal self-assessment
13.2.2. Delivery of clinical audit plan
13.2.3. Health, safety and fire inspections
13.2.4. Internal infection control visits
13.2.5. Health Inspectorate Wales peer reviews
13.2.6. Internal audit reviews
13.2.7. Internal assessment of risks

13.3. Risks identified will be escalated in accordance with the thresholds set out in the Risk Tolerance Matrix.

13.4. Quality impact assessment tool

13.4.1. A Quality Impact Assessment Tool provides a consistent approach to ascertaining the impact on quality associated with service changes.

13.4.2. It is intended to support quality governance by assessing the impact of CIPs and service change on quality.

13.4.3. It involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

13.4.4. Where a negative impact score of 9 and above is identified a detailed quality impact assessment is required, with associated mitigations.

13.4.5. The Quality Assurance Committee will monitor action plans associated with a negative impact score of 15 and above, and also action plans resulting in a

positive impact. Quality impact assessments with an adverse impact will be generated onto the Health Board risk register and monitored in line with other quality risks

13.4.6. Risks will be escalated in accordance with levels set out in the *risk tolerance* matrix.

13.5. Learning from external sources

13.5.1. The Health Board will put in place a Development Programme that incorporates learning from various sources, such as coroner interventions and inspections by the Health Inspectorate Wales for example.

13.5.2. Where appropriate and relevant, the Board will delegate the monitoring of action plans to specific Committees, receiving assurance through Chair Assurance reports.

13.5.3. The Health Board ensures that there is a systematic approach to the analysis of incidents, complaints and claims to enable learning and improvement as part of the implementation of this strategy.

13.5.4. The Executive Directors will instigate a robust process to ensure that risks identified from learning are added to the corporate risk register, where appropriate, with associated action plans which are reviewed regularly by the Risk management Group.

13.6. Early Warning Trigger Tool

13.6.1. The Health Board will develop an Early Warning Trigger Tool (EWTT) with a set of automatically weighted indicators (with a possible maximum score of 50) which taken together indicate how well a ward is functioning, and provide an early warning, pre-empting more serious concerns and enabling action before things go wrong.

13.6.2. The output of the EWTT enables ward managers and Divisional directors to benchmark the overall risk on their wards with others, resulting in the rapid identification of remedial action

13.6.3. The EWTT provides robust and reliable information from 'Ward to Board' offering the Health Board further assurance of the quality of care specifically at an individual clinical team level.

13.6.4. The EWTT will also be adapted for use in non-clinical areas applying 'early warning' metrics such as sickness absence, freedom to speak up issues, never events, near misses

13.6.5. The table summarises the risk escalation process based on ranges of EWTT scores:

Score Analysis Guide	**Early Warning Trigger Tool score**
Executive Team monitoring and Health Board escalation and assurance	**40-50**
Health Board-wide Performance monitoring , Executive Director monitoring and Quality Assurance Committee escalation and assurance	**30-40**
Divisional Director and Health Board-wide Performance Executive Committee escalation	**20-30**
General Manager escalation	**10-20**
Service /Ward Manager escalation	**0-10**

14. REACTIVE RISK MANAGEMENT APPROACH

14.1. As part of delivering this strategy, the Health Board will identify risks arising from serious incidents, claims, complaints and incidents and form action plans to reduce risks to a tolerable level.

14.2. The Health Board operates a fair, Just culture to ensure staff feel able and confident to report events or concerns.

14.3. Risks arising from complaints, Incidents and near misses rated 9 or above ('amber' or 'red') using the Risk Scoring Matrix will be entered on the Health Board Risk Register

and escalated in accordance with the Health Board's risk escalation process as articulated in the risk tolerance matrix

14.4. Claims scored using the Health Board's Risk Scoring Matrix and those rated 9) or above) will be entered on the Health Board Risk Register and are escalated in accordance with the Health Board's risk escalation process.

14.5. The Lead Director responsible for risk management will ensure a process is in place to review reports produced by Internal and External Audit with an audit opinion of limited assurance ensuring risks are identified and placed on the risk register as appropriate.

15. REGULATORY COMPONENTS OF RISK MANAGEMENT

15.1. In delivering this strategy the Health Board will consider the following aspects of statutory compliance, and the management of associated risks.

15.1.1. Health and Safety Legislation

15.1.1.1. The Health Board will discharge its statutory responsibilities under the EC framework directive (89/91/EEC) and the Management of Health & Safety Regulations 1992 (Amended 1999) to 'evaluate the risk to the safety and health of workers and anyone else who may be affected by its activity but not in its employment'.

15.1.2. Health Inspectorate Wales

15.1.3. Statutory Annual Governance Statement Disclosure

15.1.3.1. The Health Board will put in place robust arrangements to comply with requirements from the Annual Reporting Manual in relation to the production of an annual Governance statement disclosure which is assured by an effective risk management system.

15.2. Monitoring the Implementation of this Strategy

15.2.1. The implementation of this strategy will be monitored by:

15.2.1.1. Routine monitoring of the risks by the Quality Safety and Experience Committee, and independent assurance updates to the Audit Committee

15.2.1.2. The Health Board's progress against its strategic and corporate objectives.

15.2.1.3. Assurance from internal and external audit reports that the Health Board's risk management systems are being implemented.

15.2.1.4. Annual updates to the Board as part of the year-end review.

15.2.1.5. An external review of governance and leadership every three years in line with the UK Corporate Governance Code provisions.

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	RM01 – Risk Management Strategy
Date form completed:	Originally completed 02/09/2021 Reviewed and minor amendments June 2022

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	RM01 – Risk Management Strategy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Health Board aims to provide a structured, comprehensive, and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities, as the effective management of risks is an inherent part of its approach to continuous learning, improvement and good governance. RM01 – Risk Management Strategy provides a framework and structure for the consistent management of both operational and strategic risks, as drivers for better decision-making and the provision of high quality, personalised, patient-centred care, and enhanced experience.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Board Secretary
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Board Assurance Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Datix Risk Register – Procedure and User Guide (RM02) Associated Risk Management Policies, Procedures, and Guidance
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The Board and all employees.

Part A Form 1: Preparation

Please answer all questions

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The Corporate Risk Team launched an initiative to train 1000 staff across the Health Board in risk management for 2021/22, with various training slots advertised on the intranet and staff informed and encouraged to book. The plan is for all staff (including Board Members) in the next few years to receive training and/or refresher in risk management that is appropriate to their roles and responsibilities, however it is difficult for managers to find time to release staff from clinical duties to attend the training. Plans include the addition of a short version of Risk Management/Awareness Training into the Health Board's Corporate Induction Pack for new starters.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The Strategy describes the Health Board's approach to risk management as proactive, integrated, enterprise-wide and informed by an open and transparent culture in which staff feel empowered and confident to raise and discuss risks without fear, to engage staff across the entire organisation in exploring risk management as a tool for better decision-making and in achieving the objectives of the Annual Operational Plan 2021-22. The Strategy sets out the Health Board's Risk Appetite Framework, with a proactive, inclusive, and enterprise-wide approach to risk management.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below) *for further direction on how to complete this section please click here training vid p13-18)*	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** **Hint/tip: do not say: "not applicable", "no impact" or "regardless of…". If you have identified 'no impact' please explain clearly how you came to this decision.**		

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. **For the definitions of each characteristic please click here**					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Disability		No	+ve		Whilst the Strategy does not discriminate, the assessment has highlighted the need for, along with all other Health Board documentation, availability in a format to address any visual impairment disabilities, including colour blindness, and also, potentially, dyslexia.	This assessment highlighted that for those with visual impairment disabilities, additional support may be required – i.e. document transcription and additional support. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column in working documents. In terms of dyslexia, a number of Health Board resources are

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

						available to support staff as a mitigating action.
Gender Reassignment		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Pregnancy and maternity		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Race		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Religion, belief and non-belief		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Sex		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Sexual orientation		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Marriage and civil Partnership (Marital status)		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Socio Economic Disadvantage		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166 and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	No				The Strategy does not impact upon people's Human Rights – it sets out an inclusive, enterprise-wide approach to risk management.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		No	+ve		Whilst the Strategy does not discriminate, as with all Health Board documentation, the assessment has highlighted the need for availability in a Welsh language format.	The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.
Treating the Welsh language no less favourably than the English language		No	+ve		Whilst the Strategy does not discriminate, as with all Health Board documentation, the assessment has highlighted the need for availability in a Welsh language format.	The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	The Strategy underwent Health Board consultation, approval and ratification, involving those responsible for Equality Impact Assessment.
Have any themes emerged? Describe them here.	One of the Board members recommended the consideration "of staff who may be colour blind (RAG ratings) and anyone with dyslexia".
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	This assessment highlighted that for those with visual impairment disabilities, additional support may be required – i.e. document transcription and additional support. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column in working documents. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action.

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	RM01 – Risk Management Strategy

2. Brief Aims and Objectives: (Copy from Form 1)	The Health Board aims to provide a structured, comprehensive, and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities, as the effective management of risks is an inherent part of its approach to continuous learning, improvement and good governance. RM01 – Risk Management Strategy provides a framework and structure for the consistent management of both operational and strategic risks, as drivers for better decision-making and the provision of high quality, personalised, patient-centred care, and enhanced experience.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes ☐	No ☒

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes ☐	No ☒
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes ☒	No ☐

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes ☐	No ☒
	The Strategy states that for those with visual impairment disabilities, document transcription and support are available. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action. The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes ☐	No ☒
	How is it being monitored?	The Health Board will undertake regular Risk Management Self-Assessments via the Risk Management Group, to measure the effectiveness of risk management arrangements across its services.
	Who is responsible?	The Risk Management Team and the Risk Management Group.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	Annual internal audits, Snapshot Audits and/or an annual health check of risk management culture, using agreed Key Performance Indicators (KPIs).
	When will the EqIA be reviewed?	In line with the Strategy review cycle of business.

7. Where will your policy or proposal be forwarded for approval?	Audit Committee.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Justine Parry Molly Marcu	Assistant Director of Information Governance and Risk, supported by the Head of Risk Management and Assurance and the Interim Risk Project Manager Board Secretary
	Justine Parry Molly Marcu	Assistant Director of Information Governance and Risk Board Secretary
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No potential negative impacts identified, therefore no further actions required.		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	No changes required.		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	Already in place. The Strategy states that for those with visual impairment disabilities, document transcription and support are available. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action. The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column for all associated risk management materials as these are updated, going forward.	Head of Risk Management and Assurance.	As associated documents are updated.
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column for all associated risk management materials as these are updated, going forward.	Head of Risk Management and Assurance.	As associated documents are updated.

Audit Committee Paper

Cyfarfod a dyddiad: Meeting and date:	**30th June 2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Chair's Assurance Report From the Risk Management Group (RMG)
Name of Chair	Dr Nick Lyons Executive Medical Director
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	David Tita, (Head of Risk Management)
Craffu blaenorol: Prior Scrutiny:	Risk Management Group on 5th April 2022
Atodiadau Appendices:	N/A

Argymhelliad / Recommendation:

The Audit Committee is requested to note this report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	✓

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Due regard of any potential equality/quality and data governance issues has been factored into creating this report.

Sefyllfa / Situation:

The Risk Management Group (RMG) met on 5th April 2022. The Group was quorate with good representation. The Chair welcomed everyone and requested that the group did not go through introductions to save valuable meeting time. The following highlights emerged from the meeting:-

- Through the use of `check and challenge` and `deep dive` as tools for driving learning, sharing best practice and enhancing organisational risk management footprint, members of the RMG were critical of the use of expressions such as `…policy in place` or `business case in place` as risk controls. After some discussion, members noted that mentioning the development of a business case as a risk mitigation isn`t robust enough as what is important is indicating how the business case once developed will help in mitigating either the likelihood and/or impact were the risk to crystallise. Members agreed that such controls are weak and advised that they should be reviewed and strengthened.

- Members also agreed as an action that once Executive Directors have approved risks, there was no need to present them to the RMG, Executive Team or Committees for further approval as this doesn`t align with best practice or support dynamic and timely escalation of risks. This aligns with the UK Code 2018 and the FRC Risk Guide 2014, which advise that Committees should focus on their `oversight function` and not to get involved in the operationalisation of risk management by satisfying themselves that Executive Directors are consistently mitigating and managing risks in line with best practice. This will be developed and reflected in the updated Risk Management Strategy in view of approval by the Board in July.

This paper will present highlights of the discussions that took place at the RMG while underlining any key recommendations that were made.

Cefndir / Background:

- **Minutes**
  The minutes from the meeting of 7th February 2022 were checked for accuracy and a request for job titles to be verified to ensure they align with the current organisational structure was noted. The minutes were approved subject to a verification and alignment of job titles.

- **Meeting Action Tracker**
  Scrutiny of the Risk Management Action Tracker took place and the Chair suggested that the group does not go through the action log line by line and that the actions were updated outside the meeting. He also noted that the group had an action log that was not completely updated and that some of the actions appear to be significantly overdue and asked members to provide updates on the actions against their initials. The Chair then took an action to meet with the Assistant Director of Information Governance and Risk to review the action log to ascertain if aged long actions that had been assigned to colleagues who have left the organisation could be evidenced and closed or transferred to their successors or other colleagues within their service.

- **Board Assurance Framework (BAF) Risk Reviews**
  A verbal update on the BAF was presented in light of the Board workshop that was due to be held on Thursday, 7th April 2022. There was some good news around the process that was undertaken through Datix to try to standardise the approach to scoring risks, which recognises the need for all BAF risks to be migrated onto and managed via Datix in line with other organisational risks. This will be very important for two things; first, it will bring the management of the BAF (currently managed via a spreadsheet) in line with Datix and best practice. Second, it will prevent discrepancies, variation and foster a culture of consistency in how risks are assessed, quantified, controlled and managed across the business.

  Further updates on this ongoing piece of system-wide improvement work were provided; of meetings that have taken place with risk owners, which have informed an interim position and of final steps to align BAF risks with the IMPT while sense checking against the proposed risk appetite. This is important, as it will enable us to establish consistency in the application of the risk appetite in demonstrating the level and type of risks the Health Board is prepared to pursue in delivery of its IMPT.

- **Review of the Tier 1 Corporate Risk Register (CRR)**
  A review was undertaken of the CRR risks, noting that the Corporate Risk Team regularly meets with the lead risk officers to support them in reviewing and updating their risks on the CRR. Recommendations from RMG on the risks continue to be presented to the Executive Team for agreement before presentation to the appropriate Board level Committee for approval and oversight.

In reviewing the CRR, controls and mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Statement. Feedback has been provided to individual Executive Directors and Lead Officers to ensure all risks are updated before the next submission to the appropriate Committees of the Board due from March to June 2022, with presentation to the Board in July 2022.

RM22.23.06b - CRR21-11 target risk score explanation
This paper from the Informatics team was included to provide an explanation and to seek support from the RMG as they had revamped CRR21-11 and set its target score outside the Health Board risk appetite framework.

RM22.23.06c - Heightened Cyber Security threat
This paper was only included for information and to help shed light on the potential cyber security threat especially with the increase in Zero day attacks due to the ongoing war in Ukraine. Members were informed of the fact that the cyber security threat is heightened.

A deep dive session then took place into the following CRR risks, with assurance and further updates provided by the risk lead officers:

RM22.23.06d – CRR21-13 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)
This risk, which underlines difficulties with recruiting to nurse staffing posts, is unchanged and currently scored at 16. After some discussions members requested for it be completely revamped to align the risk with its current position, strengthened and some new controls added to address the safety exposure component of the risk. This is currently being progressed with the Lead Officer and will be presented at the next RMG.

- **RM22.23.06e - CRR21-14 - There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.**
Members were informed that the target risk date of October 2022 would be modified in light of the delay from the legal footprint with the implementation of the code of practice and the activities. Member were also updated on the increase in the application for depravation of liberty safeguards (DoLS) to 44%, which is significant and is continuing to increase which aligns with the current position with the risk of unlawful detention.

  Members discussed an example of a case of unlawful detention in which a patient was awarded £1500 a day compensation for unlawful detention with additional consequence of reputational damage for the organisation. Members were informed of some the challenges for the service at the level of activity as legislative changes would need to be in place to accommodate changes triggered by case law. Member were then given an example that 16/17 year-olds are now included in DoLS activity which pauses key challenges.

  Members noted the successful acquisition of Welsh Government funding to provide additional resources to help in reducing the backlog of activity, to allow for out-of-hour presence and weekly ward contacts to ensure key times, skills and activities are met. However, due to a) the delays in liberty protection safeguards and code of practice, b) in relation to additional staffing to undertake this, money would not be available until quarter 3. Available resources have been utilised and therefore, the service is exploring additional controls to help mitigate the residual risk.

5. **New risks for escalation consideration**
   The following new risks that were escalated by clinical services were presented, scrutinised and approved for inclusion onto the CRR:-

- **RM22.23.07a – 4200- There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinants**
- **RM22.23.07b – 4201 - There is a risk that adults who are an overweight or obese will not achieve a healthy weight due to engagement & capacity factors.**

Members reviewed the above two new risks for escalation that were presented by Public Health and although both risks relate to healthy weight, they are however different. Risk **ID 4200** relates the wider determinant, in which BCU Public Health is working in partnership with external stakeholders within the collaborative space to address. Risk **ID 4201** on the other hand relates to engagement and capacity issues. Both risks highlight the work around obesity and overweight in North Wales, and the fact that there is still some way to go. There is currently no capacity to treat what needs to be treated; equally, there is not enough work yet underway. Both risks was presented in the context of Welsh Government ask on Healthy Weight, Healthy Wales, which is an all Wales ask for us to step up our work to tackle and support this agenda to help people lose weight in North Wales and to stay a healthy weight.

After some discussion members agreed that both risks are real and reflect some challenges as they can`t be mitigated and managed by the Health Board alone. Hence, they advised that gaps in controls be updated to recognise difficulties arising from working in collaborative space. Both risks were recommended for inclusion onto the CRR/Tier 1 subject to mild tweaking of controls

- **RM22.23.07c - 4241 - Inability to deliver timely Infection Prevention & Control services due to limited capacity**
- **RM22.23.07d – 4325 - Potential that medical devices are not decontaminated effectively so patients may be harmed.**

Risk **ID 4241** around the inability to deliver Infection Prevention (IP) services due to limited capacity and a recognition of the need to rethink how to fill capacity gaps in the IP workforce. IP Service are not getting any uptake despite adverts as there are more posts being advertised than a suitable pool of staff with the right skills, knowledge and expertise. Risk **ID 4325** on the other hand, refers to the inability to appropriately decontaminate medical devices due to ageing equipment and the lack of robust approved SOPs on decontamination.

IP Service is now thinking outside the box as they are starting to grow their own local talent pool, are bringing in more junior staff to do basic stuff and refining what Infection Prevention and Control (IPC) nurses are asked to undertake. There are also some programmes being promoted to get clinical staff better educated on IPC, i.e. the Massive Opened Online Course that is now available online. Other solutions include, as some organisations have suggested the use of Physician Associates (Pas) in IPC roles. After some discussion, both risks were approved for the CRR/Tier 1 subject to a review and strengthening of their controls and actions.

- **RM22.23.07e – 3731 - Delivery of safe and effective resuscitation may be compromised due to training capacity issues**.

This risk focuses on our inability to deliver safe and effective resuscitation services due to the lack of capacity to meet the mandated training demands for resuscitation training across the Health Board. There are two major components to the risk, and the largest one being the lack of resus training accommodation and in the Central locality where there is currently no dedicated resuscitation training accommodation at all, which puts a third of the clinical

workforce at significant disadvantage when trying to access mandated training. The knock on effects from these hazards, include potential patient deterioration, which may be unnoticed or unrecognised in a timely way. The second component of this risk is the potential increase of cardiac arrest rates and a failure to resuscitate to nationally approved standards.

Members were informed that we are starting to see related incidents reported on Datix that even members of the cardiac arrest teams and other emergency response teams are now out of date with their resuscitation training. A third of the clinical workforce are either struggling to get on the training or are non-compliant. Recent headline news especially around maternity services emphasise the importance of newborn resuscitation training especially as our midwifery services are also struggling to meet their resuscitation trainings.

After some discussions, members advised that this risk be taken away and reviewed to:-

- ✓ capture the full impact on patients,
- ✓ align with the manual handling training as both risks refer to the lack of accommodation to deliver mandatory training and
- ✓ if possible to dovetail with risk **ID 1087**- (There is a risk to patient safety if staff are not trained and competent in the use of high risk medical devices).

A follow-up meeting took place on Monday 25th April to discuss this risk as advised by the RMG. (The meeting established that £140,000 is needed to address this risk by leasing accommodation to deliver resus training and that the risk should be widened to assume a BCU-wide perspective while some data on compliance training should be incorporated in the SBAR accompanying the risk assessment).

6. RM22.23.08a: Risk Management & Board Assurance System Development - v2
RM22.23.08b: Risk Management & Board Assurance Systems Development - Project Plan

The Chair apologised that there was not enough time to go through the papers around risk management and board assurance systems development and the associated project plan. However, he asked the group to send any comments and suggestions to the Head of Risk Management. He then asked the group to approve the papers subject their comments, which will be formally recorded in view of the next meeting.

7. Directorate Risk Register Reports

Six Directorate Risk Register Reports were presented for discussion in line with the RMG`s Cycle of Business. The reports reflect the level of risk management maturity and compliance with the Risk Management Strategy within Directorates. The Corporate Risk Team is in regular contact with Directorates across the Health Board to provide support with ensuring that their risks are often reviewed and in date. Members agreed that it would be helpful for the Directorate risk register reports to have some sort of notes to guide people through the relevant sections to facilitate understanding and engagement. The Chair advised that those presenting Directorate risk reports should assume that the papers have been read and proceed to provide succinct summaries only as this is due to time constraints.

RM22.23.09a - NWMCS risk register report

This report highlighted risk ID 1078- (**There is a risk to patient safety if staff are not trained and competent in the use of high risk medical devices**) which has been discussed within item **RM22.23.07e – 3731** – **(Delivery of safe and effective resuscitation may be compromised due to training capacity issues**). Risk ID 1087 refers to a Regulation 28, which

was issued to the Health Board in 2016. NWMCS raised concerns that the appropriate mitigation and management of risk ID 1087 shouldn`t sit with their service as it refers to wider training around medical devices much of which doesn`t sit within their remit. It was therefore requested for a meeting to be arranged to discuss and agree the appropriate parentage for risk ID 1087. Meeting is planned for Wednesday 11th May. The report was noted as received.

RMG22.23.09b – Women and Maternity risk register report
This report highlighted the fact that Womens` and Maternity are in the process of developing their RM04 in line with Health Board's procedures for risk management or the RM02 that was published on 17th of March 2022. The report underscored the need for improvement in compliance with the completion of actions implemented in mitigating and managing risks. The report noted that the service is in the process of working through its overarching risk treatment plan to align all the actions with the 24 risks on their risk register. Although the service doesn`t currently have any risk on tier 1, they however, have three high level Tier 2 risks scored at 12. The first relates to planned care within Gynaecology, the secondly refers to gestational age (SGA) babies and the risk of not being identified in antennal period leading to stillbirths while the third refers to continued perceived concerns regarding commissioned services from the Countess of Chester Hospital (CoCH). Members were assured that actions are currently in place to mitigate and manage the above risks.

The report also flagged an emerging risk around the lack of timely co-working with neonatal services in investigating some Serious Incidents Reports (SIRs) due to the inability to work together to meet the timeframes and targets set for investigations. Members queried if there are any implications from the recently published Ockenden report and were informed that this will be the focus of a meeting between the Welsh Government and maternity services across North Wales that is planned for 14th of April. There are 13 immediate actions that will need to be addressed; however, they require that Welsh Government steer and the Maternity Officer for Wales to agree a way forward before each individual Health Board will then address them. Following the meeting on 14th of April, the service would be able to assess any emerging risks and reflect them appropriately. The report was noted as received.

RM22.33.09c – Office of the Medical Director (OMD) risk register report.
The OMD Directorate Risk report highlighted the recurring theme of perceived uncertainty arising from awaiting a clarification of the governance structure as part of the reorganisation as this appears to be a barrier particularly around staffing components. The report noted the ongoing piece of work aimed at mitigating risk ID **4319- (Lack of assurance regarding NICE implementation)** as a review has been planned for 6th May with presentation of the action plan at the Clinical Effectiveness Group (CEG). The report also highlights the lack of capacity within the Clinical Effectiveness team as reflected in risk IDs **2961 – (Clinical Audit & Effectiveness Department resourcing)** and the lack of a digital system for the management and communication of results as encapsulated in risk ID 4184- (Results Management pan BCU). Both risks are currently monitored and developed with the view of escalating if need arises. The reported was received and noted.

The Chair left the meeting at this point to join another meeting which he was chairing and asked the Board Secretary to preside over the meeting through the rest of the items on the agenda.

RM22.23.09d - Finance risk register report
The report lighted the fact that the finance, which had been made available to the Health Board over the last two years due to Covid-19, will soon end. This poses a challenge for the Health

Board in the sense that although it has been in a good financial situation over the last two years and will continue to be over the next year, its negative financial position or deficit might not necessarily disappear or change. This chimes with the new BAF risk around financial sustainability. After some discussion, members were informed of the potential risk of the Health Board tipping into financial special measures if we overspend and are in financial problems this year as the Welsh Government could decide to place us in special measures at any time during the year. The report was noted as received.

RM22.23.09c – Office of the Nurse Director (OND) risk register report
This report noted the emerging risks in resuscitation service and decontamination in Infection Prevention and Control (IPC), which has been discussed. It also highlighted the ongoing piece of work on getting key stakeholders around the same table to discuss and risk assess clinical risks (like inpatient falls) since these span across a single portfolio and aren`t easy to capture on Datix which doesn`t permit multiple ownership of risks. There was a further discussion and reference to the new RM02 as it outlines a clear process to facilitate horizontal collaborative mitigation and management of Pan-BCU risks while identifying and agreeing on the lead partner, Site or service, which is eventually captured on Datix as the risk owner.

RM22.23.09e – Workforce and Organisational Development (WOD) risk register report
This report was noted as received as the presenter had left to join another meeting.

8. **RM22.23.10 - Chair's Assurance Report from the Strategic Occupational H&S Group (SOSH)**
This report provided an update from the (SOSH) group around the fact that the Health and Safety Executive (HSE) has agreed we are compliant with the improvement notice that was issued because of manual handing porters in Bangor and inpatient falls. Members were informed that the HSE would be coming back on 18th May to ensure that risk assessments relating to inpatient falls and manual handling of patients on wards are being timely and appropriately completed in line with guidelines and best practice. After some discussion, members noted the ongoing piece of work by the H&S and Falls teams as they are jointly visiting wards to ensure that documentation and training are in place.

9. **RM22.23.12 - Once for Wales (OFW) Risk Module Update**
Members were updated on the fact that a project plan has been agreed in principle although it is still in the development phase as it is due to be sent off to Datix for agreement and implementation. Members were informed of the inability to extract data to furnish the nursing quality dashboard from datix and that there was no date as to when this would be resolved which poses a risk around assurance reporting.

10. **The following emerging risk was identified from a report for further work-up:**

- Digitalisation, management and communication of results – to be articulated with lead officers and presented for approval at the next meeting.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

This report aligns with the Health Board`s Risk Management Strategy.

Opsiynau a ystyriwyd / Options considered
N/A

Goblygiadau Ariannol / Financial Implications

There are no financial implications linked to or highlighted in the report.

Dadansoddiad Risk / Risk Analysis

This report underlines the importance of appropraite and dynamic risk management, governance and report as key for embedding a positive risk aware culture and delivering assurance to the different stakeholders.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal implications related to this report.

Asesiad Effaith / Impact Assessment

Due diligence and regards has been taken to ensure that this report aligns with the Impact Assessment embedded in the Risk Management Strategy.

Report title:	Corporate Risk Register Report		
Report to:	Audit Committee		
Date of Meeting:	Thursday, 30 June 2022	Agenda Item number:	-----
Executive Summary:	The purpose of this standing agenda item is to provide a position of activity for the Corporate Risk Register since the last RMG and presents the changes that have been captured following a review and update of the risks by various risk officers of risks on the CRR, noting the support provided by the Corporate Risk Team. Once reviewed, risks on the CRR are submitted to the relevant Executive Directors for approval and sign off prior to their inclusion and presentation to the RMG and the appropriate Board Committee thereafter for scrutiny oversight. In reviewing the CRR controls and mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Framework. The CRR enables the Board to fulfil its obligations of ensuring there are effective and comprehensive systems and processes in place to identify, understand, monitor and address current and future risks deemed high enough to negatively impact on the delivery of operational objectives, whilst evaluating the effectiveness of their controls, and monitoring associated action plans.		
Recommendations:	The Committee is asked to: 1. Review, scrutinise and discuss the report. 2. Gain assurance that the Health Board`s Risk Management arrangements are effective and fit for purpose.		
Executive Lead:	Nick Lyons, Executive Medical Director		
Report Author:	David Tita, Head of Risk Management Justine Parry, Assistant Director of Information Governance and Risk		
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒

Assurance level:	Significant ☐	Acceptable ☒	Partial ☐	No Assurance ☐
	High level of confidence/evidence in delivery of existing mechanisms / objectives	General confidence/evidence in delivery of existing mechanisms / objectives	Some confidence/evidence in delivery of existing mechanisms / objectives	No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Link to Strategic Objective(s):	See the individual risks for details of the related links to Strategic Objectives.
Regulatory and legal implications	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below	**N**

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

Os yw'r adroddiad hwn yn ymwneud â 'phenderfyniad strategol', h.y. bydd y canlyniad yn effeithio ar sut mae'r Bwrdd Iechyd yn cyflawni ei bwrpas statudol dros gyfnod sylweddol o amser ac ni ystyrir iddo fod yn benderfyniad 'o ddydd i ddydd', mae'n rhaid i chi gynnwys Asesiad o Effaith Cydraddoldeb (EqIA) ac asesiad effaith economaidd-gymdeithasol (SED) fel atodiad.

A Quick Guide as to which decisions need an EqIA / SEIA is available here.

Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	See the individual risks for details of the related links to the Board Assurance Framework.
Financial implications as a result of implementing the recommendations	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Workforce implications as a result of implementing the recommendations	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Feedback, response, and follow up summary following consultation	The Risk Management Group met on the 5th April and 31st May 2022 and further updates to the risks have been incorporated. Please see the individual progress notes on each risk.
Links to BAF risks: (or links to the Corporate Risk Register)	See the individual risks for details of the related links to the Board Assurance Framework.
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:
The Risk Management Group will be meeting on the 2nd August 2022, therefore an updated position of the risks will be presented during the Audit Committee meeting of 27th September 2022.

List of Appendices:
Appendix 1 – Corporate Risk Register
Appendix 2 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score
Appendix 3 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels

Audit Committee
30th June 2022
Corporate Risk Register Report

1. Introduction/Background

1.1 The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR reflects the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

(NB Work is underway to redesign Committee Risk and Board Assurance Framework reports as part of the new, incoming Once for Wales RL Datix Cloud IQ Risk Module developments)

2. Body of report

2.1 The Risk Management Group met on the 5th April and 31st May 2022 to review the Corporate Risk Register which included a "deep dive" into the below risks as a tool for driving learning, sharing best practice and enhancing the Health Board's risk management footprint. For example, members noted that controls when expressed as `…policy in place` or `business case in place` were not properly articulated. They then advised that such controls be refreshed to focus on their implementation as neither a policy nor a business case in itself can mitigate a risk.

- CRR21-13 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).
- CRR21-14 – There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.
- CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.
- CRR21-17 – The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out of hours.

2.2 The Group also agreed that once Executive Directors have approved risks, there was no need to present them to the RMG, ET or Committees for further approval as this doesn`t align with best practice and the dynamic and timely escalation of risks. This aligns with the UK Code 2018 and the FRC Risk Guide 2014, which advise that Committees should focus on their `oversight function` and not to get involved in `risk management` by satisfying themselves that Executive Directors are consistently mitigating and managing risks in line with best practice. This will be reflected in the updated Risk Management Strategy to be presented to the Board in July 2022 for approval.

2.3 The following risks have been escalated and incorporated onto the Corporate Risk Register:

- CRR22-18 – Inability to deliver timely Infection Prevention and Control services due to limited capacity.
- CRR22-19 – Potential that medical devices are not decontaminated effectively so patients may be harmed.

- CRR22-22 - Delivery of safe & effective resuscitation may be compromised due to training capacity issues.
- CRR22-23 – Inability to deliver safe, timely and effective care.
- CRR22-24 - Potential gap in senior leadership capacity/capability during transition to the new Operating Model.

2.4 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting the breadth and categories of risks recorded in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	20	0	2	1
Tier 2 (9-12)	386	92	94	95
Tier 3 (1-8)	239	88	47	110

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

4. Risk Management

4.1 See the full details of individual risks in Appendix 1.

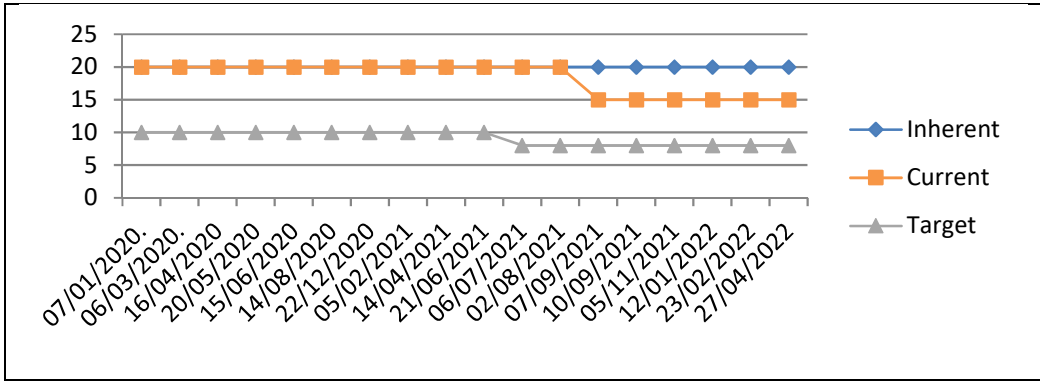
5. Equality and Diversity Implications

5.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

5.2 Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 27 April 2022
	Risk Asbestos Management and Control	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 31 March 2023

There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, Health and Safety Executive enforcement action including fines, prosecution and reputation damage to BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. 2. Annual programme of re-inspection surveys undertaken. 3. An independent audit of internal asbestos management system completed by an independent UCAS accredited body. 4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. 5. Asbestos register available.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Internal Audit review undertaken against the gap analysis.

6. Targeted surveys where capital work is planned or decommissioning work undertaken. 7. An annual training programme for operatives in Estates is in place. 8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition. 9. 5 year programme for the removal of high risk asbestos with monitoring at the Asbestos Group is in place with oversight at the Strategic Health and Safety Group. 10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework.	5. Self-assessment completed and submitted to Welsh Government which use specialist services to review the returns for consistence and compliance.

Gaps in Controls/mitigations
Not achieving 95% target for compliance with training, it is felt that due to absences 100% compliance is not achievable. Significant progress has been made in terms of training and compliance with further work ongoing, continued to increased compliance is due to long term absences. Current compliance level is 86%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by quarter one in 2022.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current status of the risk. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Target Risk Due date has been extended from the 31/03/2022 to the 31/3/2023 to allow sufficient time for: a. full implementation of actions b. training to be fully rolled out across the Health Board c. the digital platform is fully rolled out across the Health Board. 4. Action ID 12243 – Extension to the action due date to the 31/03/2023 to allow sufficient time to fully implement and roll out the digital platform. 5. Action ID 12248 – Action closed, updated Asbestos policy/procedure is available on the BCUHB Intranet, and communicated across the Health Board via the corporate weekly bulletin. 6. Action ID 18686 – Action closed, schedule now in place for training in 2022/23 which will ensure turnaround of training compliance. Training now embedded as business as usual. 7. Action ID 19758 – Action closed, audit report completed with no outstanding actions. Outcome of the report to be reported to the Occupational Health and Safety Group in May 2022.

8. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads with a proposal to re-score the current risk rating from 15 (C=5, L=3) to 12 (C=4, L=3) due to the completion of a number of actions.

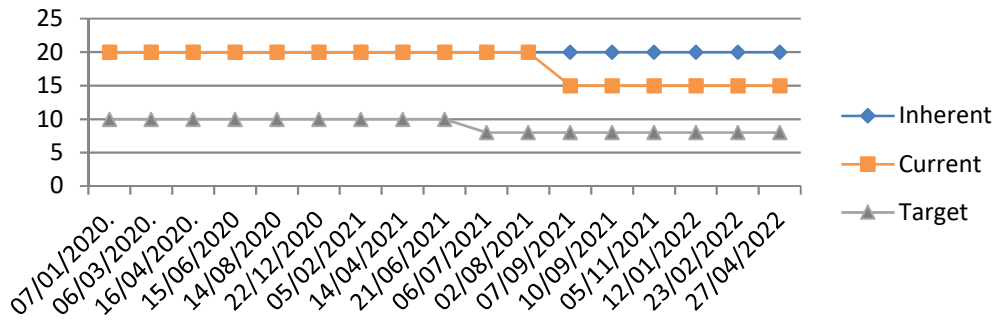
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely. This information is currently held by a third party. With the implementation of the MiCAD system, this will digitalise the information held locally by the Health Board. April 2022 progress update –	Delay

					Extension to the action due date to the **31/03/2023** to allow sufficient time to fully implement and roll out the digital platform.	
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing any potential impact. Updated Asbestos policy/procedures is available on the BCUHB Intranet, and communicated via corporate weekly bulletin. Asbestos awareness is delivered by the Estates Team upon request. Internal Audit completed providing a level of assurance. Action closed.	Completed
	18686	Ensure 100% compliance with asbestos awareness training for Operational Estates maintenance staff.	Mr Arwel Hughes, Head of Operational Estates - Interim	31/03/2022	Ensure compliance with training legislation and help to reach the target risk score. Currently on 86% compliance. Action closed, schedule now in place for training for 2022/23 which will ensure turnaround of training compliance. Training now	Completed

					embedded as business as usual.	
	19758	Undertake audits by the independent asbestos consultant to audit compliance with legislation and provide assurance in relation to asbestos management.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Provide a level of assurance in terms of compliance with legislation and provide assurance in relation to asbestos management to validate compliance and support the reduction in the risk score. April 2022 progress update - Action closed, audit report completed with no outstanding actions. Outcome of the report to be reported to the Occupational Health and Safety Group.	Completed

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 27 April 2022
	Risk: Contractor Management and Control	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 30 September 2022
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Control of Contractors Procedure in place, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 2. Induction process being delivered to new contractors, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place. 5. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation. 7. Integral evaluation process in place to monitor performance of Health Board contractors with oversight at the Occupational Health and Safety Strategic Group. 8. Approved Contractors Framework for minor works across the Health Board in place, monitored quarterly as part the Contract Performance Review.	

Gaps in Controls/mitigations
Staff resources gap due to demand versus capacity. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor. Reduction and declining of current list of requests and prioritisation of works to align with Health & Safety obligations in terms of the management and control of contractors.

Progress since last submission
1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gap in control has been updated to include the mitigation in place. 3. Action ID 12256 – Action delayed due to delays in mobilising the adoption of the SHE software which required Data Protection compliance checking to be completed. Anticipated implementation of the system is aimed for June 2022. 4. Action ID 12258 – Action delayed, Estates and Facilities have started to engage with key stakeholders around their management of control of contractors pertinent to their areas, awaiting nominated persons to be identified by relevant stakeholders. 5. Action ID 12254 – Action completed and previously approved for closure at Executive Team on the 22/12/2021, closure to be included for noting on the next Quality, Safety and Experience Committee papers prior to being archived and removed from the next iteration of the report. 6. Action ID 12255 – Action closed as processes are now in place. This action will now be archived and removed from the next iteration of the report. 7. Action ID 12259 – Action closed as processes have been reviewed and deemed fit for purpose, until such time as the current system is superseded by the new digital process. This action will now be archived and removed from the next iteration of the report.

8. Action ID 12260 – Action closed in relation to the lack of consistency and standardisation in implementation of contractor management procedure. A review of all standard current procedures has been undertaken and deemed them fit for purpose. New digital platform for the management of contractors also agreed. This action will now be archived and removed from the next iteration of the report.
9. Action ID 18688 – Action closed due to this action being incorporated within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case', managed at Tier 2 level, which includes the action to submit a business case for Executive level approval. This action will now be archived and removed from the next iteration of the report.
10. Action ID 19759 - Action closed due to this action being incorporate within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case', managed at Tier 2 level, which includes the action to submit a business case for Executive level approval. This action will now be archived and removed from the next iteration of the report.
11. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and Health & Safety Management within Health & Safety Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based	On track

					Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH) and Inspection process to ensure compliance.	
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts. Consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum Health & Safety requirements are implemented and externally checked prior to coming to site.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	ACTION CLOSED 05/11/2021 Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system. 05/11/2021 - Action closed ahead of the action due date.	Completed
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	ACTION CLOSED 12/01/2022 Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	Completed

					Processes are in place and current paper form completed and assessed. Action closed, system to be digitalised following the implementation of the SHE software.	
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE software.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of (SHE) - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor appointment criteria across the Health Board. Current robust paper based system is in place. Delays in mobilising the adoption of the SHE system in relation to Data Protection compliance checking, anticipated implementation of the system in aimed for June 2022.	Delay
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of the SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On track

					To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes.	
	12258	Identify responsible person to review Risk Assessments and signs off the Method Statements (RAMS). Skills, knowledge and understanding required to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these	Delay

					areas to ensure compliance with the Health Board Contractor Management Processes. April 2022 progress update - Estates and Facilities have started to engage with key stakeholders around their management of control of contractors pertinent to their areas, awaiting nominated persons to be identified by relevant stakeholders.	
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	ACTION CLOSED 12/01/2022 A Permit to Work system will be adopted as part of implementation of SHE software. Current paper based processes have been reviewed and deemed fit for purpose, until such time as the current system is superseded by the new digital process. Action closed.	Completed
	12260	Lack of consistency and standardisation in	Mr Rod Taylor,	31/05/2022	ACTION CLOSED 12/01/2022	Completed

		implementation of contractor management procedure picked up in Health & Safety Gap Analysis Action Plan.	Director of Estates & Facilities		Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes. Review of all standard current procedures undertaken and deemed them fit for purpose and improved standardisation of the contractor framework. New digital platform for the management of contractors also agreed.	

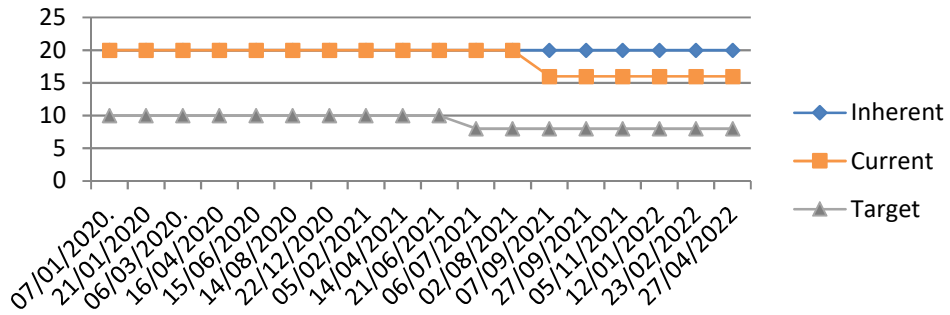
					Action closed.	
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health and Inspection process to ensure compliance. Regional framework of contractors for minor works in place, review of systems and procedures undertaken. Induction process is in place however potential gaps due to resources to align with capacity. Business case to be re-presented to the Executive Team.	On track

	18688	An annual review of business as usual capacity to be developed to ensure estates project management capacity is not exceeded.	Mr Arwel Hughes, Head of Operational Estates - Interim	31/03/2022	Create assurance that there is sufficient estates management capacity and technology to ensure that projects can be delivered safely. Action closed as this action is incorporated within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case' which includes the action to submit a business case for Executive level approval.	Completed
	19759	Funding to be secured for additional authorised/competent persons to mitigate the resource gap.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	A revenue business case for additional authorised/competent persons has been prepared and has been put forward for financial/resource consideration on a recurrent basis and will address the gap identified and support the reduction in the risk score to achieve the target. Action closed as this action is incorporated within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case'	Completed

					which includes the action to submit a business case for Executive level approval.	

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 27 April 2022
	Risk: Legionella Management and Control.	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 30 September 2022

There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place, reported to and signed off by the Water Safety Group. 2. Risk assessment undertaken by clear water, with action and issues reported to the water Safety Group. 3. High risk engineering work completed in line with Clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonas. 6. Authorising Engineer water safety in place who provides annual report.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Strategic Infection Prevention Group. 4. Quality, Safety and Patient Experience Committee.

7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety Team. 8. Water Safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken. 10. Alterations to water systems are now signed off by responsible person for water safety. 11. Local Infection Prevention Groups in place with oversight of water safety.	

Gaps in Controls/mitigations
1. There is a weakness that little used outlets are not reported to Estates for management and control. For example - ward shower temporarily used as a store, therefore it is not part of Estate flushing programme. Regular topic of the Water Safety Group which has clinical representation and feeds into local Hospital Management Teams. 2. BCUHB wide Water Safety Plan – Plan has been developed, consulted upon and final draft is being produced. Plan has also had approval from the authorising Welsh Government Appointed Engineer - Water Safety, which will provide the legal requirement under L8 for processes and controls for water safety systems. Final version completed and to be submitted in May 2022 for ratification by Infection Prevention Sub-group. 3. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case is currently unfunded and provides supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety, which forms part of the ongoing business case. Included in the Integrated Medium Term Plan, supported by risk ID 4283.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Assurances updated to ensure relevance with current risk position. 4. Action ID 12265 - Action closed as water testing is carried out by Public Health Wales who store the information on their servers. This action will now be archived and removed from the next iteration of the report. 5. Action ID 12268 - Action remains delayed with a BCUHB Water Safety Plan to be completed and submitted for ratification by the Infection Prevention Sub-Group.

6. Action ID 12270 – Action closed as a standardised maintenance strategy adopted and in place by means of single service provider. This action will now be archived and removed from the next iteration of the report.
7. Action ID 19015 - Business case now included in the scope of priorities for Integrated Medium Term Plan, which will result in a delay to the action due date of the 31/03/2022 to appoint Senior Estates Officers (Competent Persons) for water safety.
8. Action ID 19760 – Action closed as Authorising Engineer for water safety appointed in December 2021. This action will now be archived and removed from the next iteration of the report.
9. Action ID 19761 – Action closed, flushing of little used outlets now reported as part of the water safety group, currently quarterly, however will move to become bi-monthly from April 2022. This action will now be archived and removed from the next iteration of the report.
10. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance	On track

					Contract, which has been approved by the Health Board in January 2021.	
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk. Progress update – Information reported through local Infection Prevention and Control Groups. Process for information collection has been described, with the collection of information underway.	On track
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	This forms part of the Water Safety Plan to ensure water safety compliance. This will be completed and submitted in March 2022 for ratification by Infection Prevention Sub-Group.	On track
	12265	Water quality testing results and flushing to be logged on single system and	Mr Rod Taylor, Director of	31/12/2021	ACTION CLOSED 12/01/2022	Completed

		shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Estates & Facilities		Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales. Water testing carried out by Public Health Wales who store the information on their servers, BCUHB keeps the information within log books for each area and accessible upon requests by departments. Action closed.	
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B). Progress update - Escalation process is included in the Water Safety Policy, exception reports provided to the Infection Prevention	On track

					Group from the Water Safety Group.	
	12267	Awareness and training programme in place to ensure all staff aware as part of Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board. Progress update – Awareness and Training Programme now in place.	On track
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for Standard Operating Procedures and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	A policy for Water Safety Management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document. As part of the Water Safety Plan infection prevention will need to be integrated within key sections of the plan. April 2022 progress update - Comments and recommendation from authorising engineer for	Delay

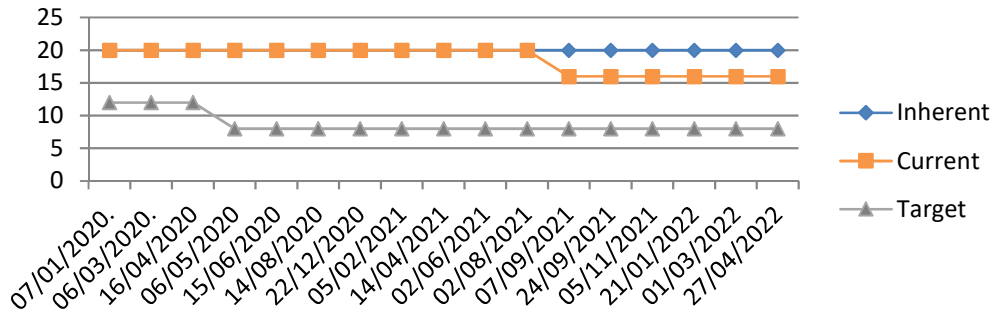
					water, infection prevention, microbiology and health and safety incorporated into the plan, to be presented in May. 2022 for ratification by Infection Prevention Sub-Group.	
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the Health & Safety Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	ACTION CLOSED 12/01/2022 Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document. Standardised maintenance strategy adopted and in place by means of single service provider. Action closed.	Completed
	19015	Secure funding and appointment of 3x band 7 Senior Estates Officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Provide resources to be able to manage safe water systems and have the facility to carry out departmental audits on water safety and provide assurance of compliance to the water safety group.	Delay

					April 2022 progress update - Business case now included in the scope of priorities for Integrated Medium Term Plan, which will result in a delay to the action due date of the 31/03/2022 to appoint Senior Estates Officers (Competent Person) for water safety.	
	19760	Confirmation that the Health Board has an Appointed Authorising Engineer for water safety, a function that is provided by NHS shared services (specialist estates services).	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	ACTION CLOSED 31/12/2021 Provide an independent Water Safety Specialist Engineer to ensure Health Board is compliant in its duties in terms of water safety, which in turn will increase the controls in place and support the reduction in the likelihood of the risk materialising. Appointed Authorising Engineer – appointed December 2021. Action closed.	Completed
	19761	Improve on the consistent reporting and the identification of little used	Mr Arwel Hughes, Head of	28/02/2022	Substantiate the adjusted lower risk score that has been signed off at committee.	Completed

		outlets in both community and acute settings.	Operational Estates - Interim		Action closed, flushing of little used outlets now reported as part of the water safety group, currently quarterly, however will move to become bi-monthly from April 2022.	

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 27 April 2022
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 30 September 2022

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Fire Safety Policy established and implemented, annual report reported to Board and supported by Welsh Government. 2. Fire risk assessments in place. 3. Fire Engineer regularly monitors Fire Safety Systems. 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken. 6. Escape routes identified and evacuation drills undertaken, established and implemented.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Annual Compliance returns submitted to Welsh Government.

7. Fire Safety Mandatory Training and Awareness sessions regularly delivered to BCUHB Staff. 8. Fire Warden Mandatory Training established and being delivered to Nominated Fire Wardens. 9. Appointed Authorising Engineer for fire safety in place through NHS shared services (specialist estates services).	

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance. Prioritisation of maintenance regimes in place by the use of risk based assessments. 2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure. Two applications to Welsh Government for Programme Business Case (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Assurances updated to ensure relevance with current risk position. 4. 2022 Fire Safety Audit completed, undergoing validation prior to submission to Welsh Government by the 31/05/2022. 5. Action ID 12274 – Extension to the action due date from the 31/3/2022 to the 31/07/2022 to allow the implementation into the new operating model for governance accountability and responsible senior staff members to be identified. 6. Action ID 12275 – Action closed as 80% compliance target rate has consistently been achieved over the past 3 years and is monitored via the Fire Safety Group. This action will now be archived and removed from the next iteration of the report. 7. Action ID 12279 – Action closed as Albac Mat training is now in place. Estates and Facilities Department provided support to develop the training programme. Manual handling training on Albac Mats is delivered by the manual handling team with refresher training delivered on request. Closure of the action recognises the link on training compliance with the manual handling department. This action will now be archived and removed from the next iteration of the report. 8. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads.

Links to

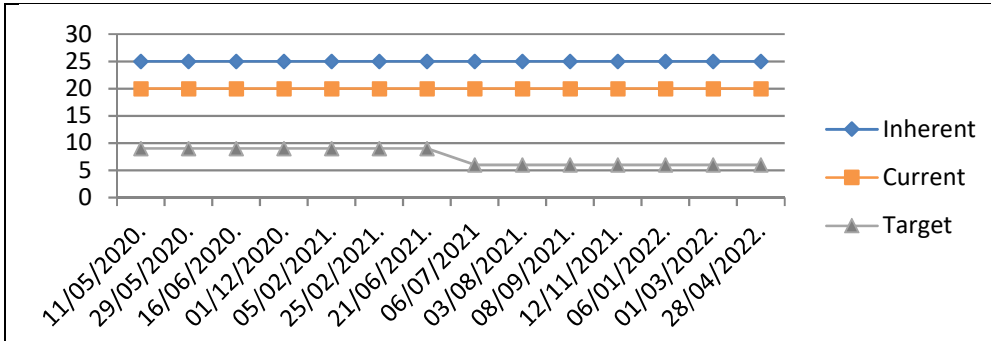
Strategic Priorities	Principal Risks
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12274	Identify how actions identified in the site Fire Risk Assessments are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/07/2022	Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on implementation of actions outstanding. April 2022 progress update - Extension to the action due date from the 31/03/2022 to the **31/07/2022** to allow the implementation into the new operating model for governance accountability, anticipated action completion will be 31/07/2022.	Delay
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of	30/06/2022	ACTION CLOSED 21/01/2022 Database located within the fire safety files, managed and	Completed

			Estates & Facilities		updated by the fire safety trainer. Action closed as 80% compliance target rate has consistently been achieved over the past 3 years and monitored via the fire safety group.	
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	To be included in site specific manual and training developed with Manual Handling Team. April 2022 progress update - Betsi Cadwaladr Health Board are part of the all Wales groups looking into the evacuation of bariatric patients, reviewed locally under the guidance of the Hospital Management Team's.	On track
	12279	Albac Mat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	ACTION CLOSED 21/01/2022 Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling Team.	Completed

					Action closed recognising the link into the Health & Safety Team on Manual Handling Training compliance rates.	
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order. April 2022 progress update - Following a successful recruiting campaign, a full complement of Fire Safety Advisors is now in place which will assist with delivering the Health Board programme of Fire Risk Assessments in a risk assessed priority.	On track
	21491	Develop and implement a BCU Fire Safety Strategy.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Fire Safety Strategy will bring all procedures, action plans etc. together to improve governance control and oversight of Fire Safety Management.	On track

CRR20-05	**Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 28 April 2022
	Risk: Timely access to care homes	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 30 September 2022
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	Assurances
1. Multi-Agency Oversight Group and Care Provider Operational Group continue to meet to oversee the ongoing Covid response, to support recovery and ensure sustainability of the sector to respond to care home and domiciliary care demand with clear pathways for escalation in place. 2. North Wales care homes single action plan provides the framework for the Multi-Agency response and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). This group will now review the Health Boards current position against the recommendations of Operation Jasmine.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight by the Regional Commissioning Board who report to the Regional Partnership Board.

3. Development of the Quality Assurance Framework - this work is overseen by a Multi-Agency Implementation Group with sign up from the 6 Local Authorities and the RPB. The work is supported by 6 work streams which picks up the ongoing work around Covid and recovery. 4. Continuing Health Care Operations Group in place to ensure the consistent implementation of the new CHC Framework, sharing lessons learnt from retrospective reviews and ombudsman reports. Co-ordination of the contracts including Pre-Placement Agreement and Commissioned Placement Fees.	

Gaps in Controls/mitigations
1. There is a significant shortage in accessing appropriate placements in care homes with a worrying trend of care home closures and homes de-registering nursing beds. The Market Stability Report is not due until September 2022. Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report. 2. Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge, but insufficient domiciliary care provision to step down to. Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report. 3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. This has been escalated to the Silver Command Operations Resilience Meeting. Work ongoing with IT department to develop digital system. This will ultimately be part of the revised Discharge Policy. Interim solution for providing consistent data will be implemented by May 2022. 4. No signed Pre Placement Agreement (PPA) - lack of controls in place for addressing concerns, monitoring quality - there is only informal voluntary co-operation. This gap in control is shared with the 6 Local Authorities. There is a joint PPA working group in place but failure to 'sign off' continues. Regional Commissioning Board has sought legal advice. 5. Commissioned Placement Fee Setting - Health Board has agreed to make an interim uplift whilst awaiting national pay awards. 6. Lack of resources to develop has resulted in the development of an integrated Health and Social Care Bank and Memorandum of Understanding to be escalated to the Regional Partnership Board and the Regional Workforce Board.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls updated to reflect that there is a work programme in place to review the discharge policy which will include a task and finish group to address the gaps in medically fit for discharge with a report providing a standardised approach for North Wales. In addition work progressing with IT looking at a national data set. 3. Assurances updated to reflect current risk position. 4. Proposal to Risk Management Group increase the target risk score from 3x2 to 4x2 for an increase from a 6 to an 8 recognising that this remains with in the Health Board risk appetite statement as the impact should the risk materialise would not reduce to a 3 from 5. 5. Proposal to Risk Management Group to extend the Target risk due date from the 30/06/2022 to 30/09/2022. The Health and Social Care transition plan is dated from April to June 2022, the extension to the Target risk due date will to allow time to interpret and implement the next stages required. 6. Pre-placement agreement now agreed by the 6 Local Authorities and Care Forum Wales and will be sent out to providers within the next two months. 7. Action ID 14949 - Action closed as now completed. This action will now be archived and removed from the next iteration of the report. 8. Action ID 18024 – Action closed as this is now captured within the current controls in place in relation to the Multi-Agency Cell which undertake the activity. This action will now be archived and removed from the next iteration of the report. 9. Action ID 18025 – Action delayed due to Regional Workforce Board not having met, this action links to action ID 20074. 10. Action ID 18646 – Action closed as this is now embedded into the controls in place identified in relation to the Multi-Agency Cell Action Plan. This action will now be archived and removed from the next iteration of the report. 11. Action ID 20074 - Action remains delayed as meeting not re-established as anticipated by the Regional Partnership Workforce Board therefore March 2022 target completion date not anticipated, work remains ongoing to progress with plan for this to be established prior to this year's winter pressures, anticipated completion by end of August 2022. 12. Identification of new action ID 22182 to review and update Health Board Discharge policy, which will support the assessment around medically fit for discharge patients. 13. Further consideration taken to develop a care provider risk, work is ongoing to develop this risk.

Links to	
Strategic Priorities	**Principal Risks**
Primary and community care	BAF21-03

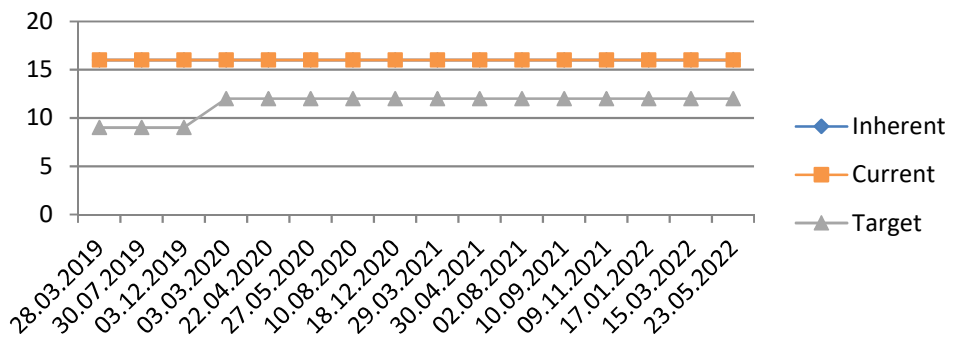
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	28/02/2022	ACTION CLOSED This will help eradicate delays in discharge through better co-ordination. Action Closed as completed, staff returned to primary roles.	Completed
	18024	To work with LAs to review domiciliary care resource across North Wales.	Ms Jane Trowman, Care Home Programme Lead	28/02/2022	ACTION CLOSED 06/01/2022 It will improve patient flow by enabling patients to be discharged to their own homes. This action is now captured within the current Multi-Agency Cell control in place which undertake this activity.	Completed
	18025	Working with the North Wales Regional Workforce	Mrs Marianne Walmsley,	30/04/2022	It will prevent admissions from Care Homes which have	Delay

		Board to develop an improvement recruitment package for Independent Providers.	Lead Nurse Primary and Community		no staff and improve patient flow to enable discharge. April 2022 progress update - Action Delayed due to Regional Workforce Board not having met, this action links to action ID 20074.	
	18646	MFD - Work with local authorities and care provides to implement an agreed action plan.	Ms Jane Trowman, Care Home Programme Lead	31/12/2021	ACTION CLOSED 31/12/2021 Improved flow and discharge of patients in a more timely manner, and improve the quality of care to patients. This action is now captured and embedded into the Multi-Agency Cell Action Plan control in place.	Completed
	20074	Development of an interim relief bank for health and social care	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/01/2022	Allow flexibility in relation to staffing within homes. This action remains delayed due to resources within the Health Board and with partners to support the COVID vaccination programme and general staffing shortages.	Delay

					April 2022 progress update - Action remains delayed as meeting not re-established as anticipated by the regional partnership workforce board therefore March 2022 target completion date not anticipated, work remains ongoing to progress with plan for this to be established prior to this year's winter pressures, anticipated completion by end of August 2022.	
	22182	Review and update Health Board Discharge policy.	Ms Jane Trowman, Care Home Programme Lead	30/09/2022	Discharge policy reviewed and updated will support the assessment around medically fit for discharge patients.	On track

CRR20-06	**Director Lead:** Chief Digital and Information Officer	**Date Opened:** 28 March 2019
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 23 May 2022
	Risk: Informatics - Patient Records pan BCUHB	**Date of Committee Review:** 20 May 2022
		Target Risk Date: 30 September 2024

There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Informatics Strategy in place, with regular reporting to Partnership, People and Population Health Committee. 2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB and monitored via the Patient Records Group. 3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place to govern the management and movement of patient records. 4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Centralised Team to manage 'Subject Access Requests' for Patient Records pan-BCUHB established with project complete March 2021, ensuring compliance with legislation and supporting the rectification of commingling within patients clinical notes. 6. Standard Operating Procedure in place pan-BCUHB and off-site storage secured to manage the increased storage demands in response to the embargo on the destruction of patient records (in line with retention) due to the Infected Blood Inquiry. 7. Medical Examiners Service (MES) support teams established on each site to respond to the new requirements for providing scanned patient records to the MES in line with their standard operating procedures.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee. 3. Information Commissioners Office Audit.

8. Baseline audit undertaken in acute mental health and Children and Adolescent Mental Health Service (CAMHS) with monitoring and oversight by the patient record group reporting to the Information Governance Group.	

Gaps in Controls/mitigations
1. Lack of ability of project resources to be able to digitalise all specialties within 4 years. Phased approach for digital implementation introduced. 2. Fit for purpose on site estate to hold physical records with the lack of current plans to scan records. The estate to hold physical records requires upkeep, current off site storage in place.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current status of the risk. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Action ID 12425 – Proposal to the Risk Management Group for an extension of the action due date from the 30/06/2022 to the 31/12/2022 due to a delay in the start of the Medical Transcribing Electronic Discharge project due to the inability to recruit resources for the project. 4. Action ID 12423, 12424 and 12429 – Action Lead/Owner updated to reflect current position.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12423	Development of a local Digital Health Records system.	Mrs Nia Aspinall - Head of Patient Records and Digital Integration	30/09/2024	Vascular Multi Disciplinary Team eForm and process has finished redesign and is in second stage of testing. Site visits have taken place with process mapping to follow for Central and West Health Records. Initial engagement continues with Lung Cancer Nurses Central and Rheumatology with progress on their eForms. Risk Sub-Group and Project	On track

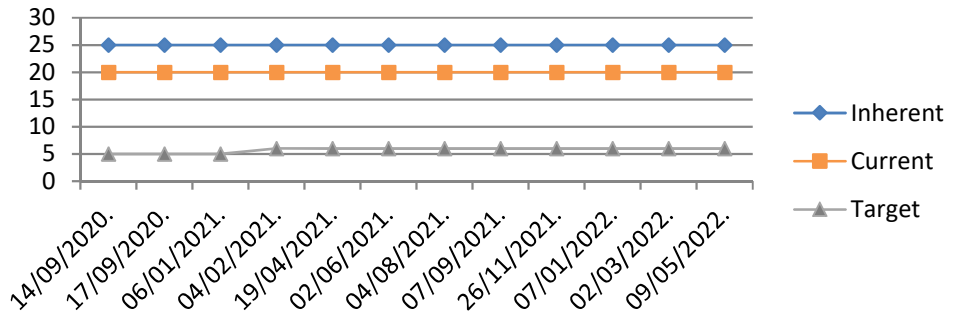
					Board remain updated via e-mail as unable to meet due to Covid pressures on key attendees. Phase 3.0 – Scanning & Upload Interviews and scoring concluded, panel have agreed to proceed with Supplier. Contract Award is pending sign off and will require Welsh Government approval. 2 Compliance & Assurance roles are with job evaluation and Work Package commenced to review new working processes and regulatory compliance. Phase 4.0 – 3rd Party Integrations EPRO can now open within Cito, testing is underway. Ingestion of 750,000 historical clinical letters has commenced. Digital Health Care Wales have acknowledge receipt of request made Summer 2021, no timescales have been provided.	
	12425	Digitise the clinic letters for outpatients.	Mrs Nia Aspinall - Head of Patient Records and Digital Integration	30/06/2022	Central – Phase 3 Completed. East - Phase 4; The following departments are now live on EPRO, Long Covid Service, CMATS, Paediatrics, Vascular, Breast, Palliative Care. Planning is underway with the remaining departments keeping the project on track for completion June 2022.	On track

					May 2022 progress update - Proposal to the Risk Management Group for an extension of the target action due date from the 30/06/2022 to the 31/12/2022 due to a delay in the start of the Medical Transcribing Electronic Discharge project due to the inability to recruit resources for the project.	
	12426	Digitise nursing documentation through engaging in the Welsh Nursing Care Record.	Jane Brady, Assistant Business Support Manager	30/09/2024	Business Case still not formally approved and is currently with Executive Director of Finance. Plan formalised for continued roll-out Pan-BCU dependant on business case approval, in order to recruit into posts required for full implementation.	On track
	12429	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Nia Aspinall - Head of Patient Records and Digital Integration	31/01/2023	ON HOLD until the Mental Health Business Case is progressed with the Welsh Government (5 case business cases) – break ground circa 2023, we will not be able to start the work to explore if the Ablett can be retained and redesigned for health records until the business cases are signed off. The date for the Mental Health Full Business Case is September 2022.	On track

CRR20-08	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 09 May 2022
	Risk Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 31 Dec 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Outsourcing process and group in place to review progress against the contract. 2. Cataract - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first.	1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative Group. 3. Monthly reports to Welsh Government against Key Performance Indicators for eye care measure and Key Quality Indicators.

3. 'Once for North Wales' process is in place, partially across all sites, Cataract patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access. 4. Once for North Wales process allows partial flexibility for cross region movement of Cataract and Intra Vitreal Injection patients and the ability to allocate further clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed. 5. Diabetic Retinopathy Integrated Pathway now in place across all 3 sites. 6. Monthly monitoring of the application of the Cataract Priority Targeting List (PTL) to ensure Pan BCU reduction of access inequity. 7. ODTC STW enabled continuation of use of Primary Care Optometry (6 until September 2022). 8. Clinical condition dashboard now available for beta stage testing to support documentation and site self-management of clinical condition use to manage services. 9. Pan BCU Clinical Lead now appointed.	4. All Wales and Mersey Internal Audit Agency audits have taken place, and reports received to which BCUHB is responding. In addition two clinical condition audits are undertaken annually by Welsh Government. 5. Performance reviewed at Secondary Care Accountability Meetings.

Gaps in Controls/mitigations
1. Further table-top risk stratification is challenged by reduced office based decision making for clinicians as a consequence of their return to expanded clinical activities. Continuing to stratify patients into R1, R2 and R3 to enable prioritisation of those at risk of permanent sight lost. In addition further capacity is planned for Intra Vitreal Therapy (IVT) across all regions as part of the approved business case and additional Central region business case. 2. Outsourcing of the cataract activity is in place along with additional temporary administration support, however, there is need for sustainability moving forward. 3. Current partnership pathways which mitigates waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition. A significant number of patients do not have a clinical condition logged on the system. Standard Operating Procedure has been refreshed and a review is undertaken with a monthly clinical condition report to monitor data quality against clinical condition and sites produce redress action plans. 4. National standard currently not being met, guidance for number of cataracts being undertaken per list is currently set to 6-8, the Health Board is running at 2.8-3.6, differences in national standards between number of cataract procedures per list.

Regional Treatment Centres and Clinical Pathways contract formally with Get it right first time (GIRFT) in ophthalmology to review, design and implement new pathways to deliver high volume low capacity productive theatre sessions. First session took place on the 28th February 2022.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Proposal to the Risk Management Group to extend the target risk due date from the 30/06/2022 to the 31/12/2022 due to the services' proposal to review the risk with a view to reflect various eye conditions as separate risks and propose the development of separate risks moving forwards. 3. Recovery funding received and additional capacity currently being implemented. 4. Action ID 14908 – Action closed following completion, and the introduction of retinal cameras across all 3 sites. This action will be archived and removed from the next iteration of the report.5. Action ID 15662 – Action closed following initiation of the pathway pan BCUHB. This action will be archived and removed from the next iteration of the report. 6. Action ID 20392 – Action delayed, recruited across all 3 sites with the exception of Consultant posts, which are currently being re-advertised. 7. Action ID 22092 – Action closed, Pan BCU Clinical Lead appointed, commenced May 2022. This action will be archived and removed from the next iteration of the report. 8. Identification of new action ID's 22092 and 22093 for the replacement of Clinical Lead for Ophthalmology and Optometric advisor.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways Strengthen our wellbeing focus	BAF21-02 BAF21-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	Mr Srinivas Singaram, Specialty Doctor	31/12/2021	ACTION CLOSED 07/01/2022 This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score. Progress to date - Action has been completed, equipment now in place across all 3 sites.	Completed
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	Mr Srinivas Singaram, Specialty Doctor	31/12/2021	ACTION CLOSED 07/01/2022 This action will enable the service to appropriately mitigate and manage this risk in attaining its target score. Progress to date – Action closed following completion.	Completed
	20392	Following approval of business case, recruitment of clinical and admin posts for Intra Vitreal Therapy capacity and technical posts for the digital project.	Alyson Constantine, Site Acute Care Director	31/12/2021	Additional Intra Vitreal Therapy capacity and more patients can be seen within target time. Technical posts will allow progression of digital implementation.	Delay

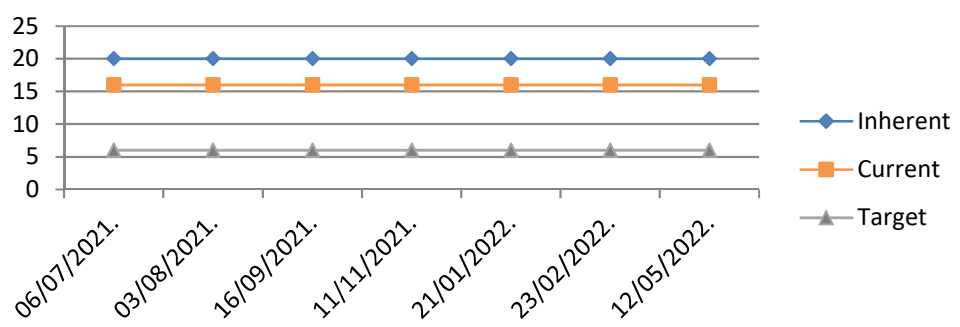
					May 2022 progress update - All posts for IVT services recruited except for Consultants.	
	20995	Training of additional non medic Intra Vitrael Therapy (IVT) injectors.	Mrs Jackie Forsythe, Eye Care Co-ordinator	30/06/2022	Additional non medic injectors will reduce waiting times for new Intra Vitrael Therapy patients which will reduce the likelihood of the risk materialising. May progress – All 3 site injectors have completed the accreditation course and are moving to practical train and treat stage.	On track
	22092	Replacement of Clinical Lead for Ophthalmology.	Alyson Constantine, Site Acute Care Director	31/05/2022	The action will result in support in the review of services across North Wales, standardisation and best practice within the service. Action Closed - Pan BCU Clinical Lead appointed, commenced May 2022.	Completed
	22093	Replacement of Optometric advisor.	Alyson Constantine,	30/06/2022	To support the communication between the Health Board and the Optometrists during the	On track

			Site Acute Care Director		implementation of the National optometry reform contract currently with Welsh Government. May 2022 progress update – Interviews for the substantive post due on the 9th June 2022, with the recruitment process and shortlisting taken place.	

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 01 December 2017
	Assuring Committee: Quality, Safety and Experience Committee Quality and Safety Group	**Date Last Reviewed:** 12 May 2022
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 30 December 2025

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.

This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Workforce Recruitment and Retention Strategy in place and actively monitored with initiatives in place to maximise recruitment and retention across the nursing workforce. 2. Nurse Staffing Policies NU28/MHLD 0028/ outlines standards and escalation in relation to identifying and mitigating nurse staffing shortfalls across wards and departments. Nurse staffing vacancies and recruitment activity is monitored through the nursing recruitment and retention group which currently reports to the Strategic Workforce Group. 3. Bi-annual Nurse Staffing calculations are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing	1. Risk CRR21-13 is reviewed and monitored at the respective local Quality and Safety meetings. 2. Compliance with the Nurse Staffing Act and Nurse Staffing calculations are reported to the Board bi-annually (May/November) via the Quality, Safety and Experience Committee as the designated committee.

calculations are also undertaken in other areas of acute services such as admission portals, Emergency Departments and areas of high care. 4. A Strategic Recruitment and Retention Group in place to monitor and develop forward look recruitment and retention initiatives to mitigate nursing shortfall over the next 5 years. 5. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to ensure roster performance is actively managed to enable maximum utilisation of nursing workforce across the Health Board. 6. Managing Attendance at Work Policy WP11 in place with sickness, absence and wellbeing pro-actively managed to ensure the nursing workforce is optimised. 7. Utilisation of the SafeCare allocate system to provide a live/real time view of nurse staffing levels, skill mix, and patient demand. The system provides nurse managers with visibility across wards and areas enabling acuity based, safety driven decisions regarding nurse staffing and the deployment of staff. 8. BCUHB Nursing Career Framework in place and utilised to develop and train our existing nursing workforce to meet identified workforce gaps and meet succession plans across the Health Board. 9. Workforce planning and commissioning process in place to triangulate the requirements to develop and deliver the nursing pipeline to meet the current and future needs within the nursing workforce across BCUHB. 10. Full representation and active participation in national policy and decisions making forums such as All Wales Nurse Staffing Group, All Wales Recruitment and Retention Group.	3. Monthly roster KPI reports are issued to identify areas in need of improvement and areas requiring targeted support. 4. Monthly SafeCare compliance reports have been developed to identify areas in need of targeted support to enable a live view of nurse staffing levels, skill mix, and patient demand. 5. Nurse Recruitment and Retention workplan aligned to organisational priorities, CNO principles and key national drivers/strategy.

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to Key Performance Indicators e.g. Annual Leave/training. A Workforce Nursing Utilisation Dashboard has been developed and introduced to senior nursing teams to optimise nurse staffing rosters. 2. Whilst adult acute medical and surgical, and Area Teams Central and West have fully implemented the Safecare Allocate System, East Area, paediatrics and Mental Health are yet to implement. Although the Health Board has been using the system for some time there has been a significant change at matron and ward manager level and it is recognised that additional support is required to these areas to re-establish the discipline and compliance required to enable acuity based, safety driven decisions regarding nurse staffing. An implementation plan will oversee the roll out in outstanding areas. The All Wales SafeCare Standard Operating Procedure will further guide and strengthen the use of the system at an operational level. The newly appointed Nurse Staffing Programme Lead will oversee the implementation and associated training requirements relating to the SafeCare System. 3. Not all Nursing staff groups are on electronic rotas and not everyone is IT literate, due to personnel changes there is a requirement for refresher training. Plan being developed to move all nurse staff groups onto roster with a specific IT training plan aligned to this initiative. 4. Whilst the recruitment and retention strategy and plan are in place, this needs updating in line with the update of the Health Board's People strategy. Individual initiatives are in place to inform data analysis and the revised strategy will take these into account along with the wider All Wales recruitment and retention initiatives. This is being led by Director of Nursing for Workforce Staffing and Professional Standards.

Progress since last submission
1. Controls in place reviewed and updated to align with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Proposal to the Risk Management Group to extend the target Risk Due date from the 30/12/2022 to the 30/12/2025 to align the risk with the Health Board's Integrated Medium Term Plan. 4. Proposal to the Risk Management Group to re-score the Target Risk Score from the current score of 6 (Impact = 3, Likelihood = 2), to a score of 8 (Impact = 4, Likelihood= 2). 5. Action ID 15635 – Action remains delayed, this action is now delayed because the new People Operating Model (Workforce) has been pulled back as it will be in place by 30/09/2022. 4. Action ID 17433 - Action remains delayed, meeting held between Nursing team and Workforce to review the action and agreement that further review in 3 months would be required. 5. Action ID 17509 – Proposal for an extension to the action due date. Following a request from the Executive Team for clarification on the time extension, this is due to the action now becoming a National Programme, looked at in the context from an All Wales perspective, and led by the office of the Chief Nursing Officer. Timeframe for completion is therefore outside the control of the Health Board which is the reason for the proposal to the timeframe extension until the 30/11/2022 is presented. 6. Action ID 18834 - Proposal for an extension to the action due date to the 30/06/2022, due to system pressures and the management of the COVID pandemic. System has developed and is in place to be implemented however due to current instability in workforce and current pressures, implementation has been delayed. 7. Identification of new action ID 23095 to develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Effective alignment of our people (key enabler)	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce	30/11/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the	Delay

to achieve target risk score			Optimisation Advisor		ability to expedite recruitment and increase volume. The individual benefits and Key Performance Indicators of the business case are linked to the relevant sections of our corporate risk register. May 2022 progress update – this action is now delayed because the new People Operating Model (Workforce) has been pulled back as it will be in place by 30/09/2022.	
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce. In 2021/2022 the Health Board embarked on an ambitious three year people and organisational development journey (Mewn undod mae Nerth/Stronger Together). This was and is aimed at enabling the organisation to move forward and deliver its Clinical Strategy/Plan through delivery of its People Strategy and Plan – Stronger Together. The feedback from over 2,000 staff has informed the development of 5 programmes of work, one of which is 'the Best of our Abilities', this includes the development of an	Delay

					integrated Leadership & Management Development Framework for all professional groups, aligned to a new Learning and Education Academy. The risk associated with the development of specific leadership offers related to specific staff groups, i.e. Head of Nursing and Ward Manager programmes will be reviewed as part of this work, with a proposal to develop a new Framework which will be inclusive of all professions and will provide a more streamlined, multi-disciplinary approach. May progress update - Action remains delayed, meeting held between Nursing team and Workforce to review the action and agreement that further review in 3 months would be required.	
	17509	Exploration of the Welsh equivalent Global Learning Programme.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2021	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS. This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development. May 2022 progress update - Action remains delayed due to the action now being superseded by the once for Wales National initiative and remains outside the Health Board	Delay

					control, BCU is part of the national group.	
	18834	Introduce targeted monitoring across rosters, through Key Performance Indicators management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Workforce Optimisation Advisor	31/12/2021	Effective utilisation of substantive staff. May 2022 progress update - Proposal of extension to the action due date to the 30/06/2022, due to system pressures and the management of the COVID pandemic. System is developed and in place to be implemented however due to current instability in workforce and current pressures.	Delay
	18835	Support and progress existing band 4 roles through to fastrack nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mrs Alison Griffiths, Director of Nursing Workforce	30/12/2022	This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce. May 2022 progress update - Action remains on track for December 2022.	On track
	20039	Develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health Board's business planning cycle.	Mandy Jones, Deputy Executive Director of Nursing	30/12/2022	By embedding into the business planning cycle this will support a more integrated approach to ensure the safe staffing act is met through pathway re-design and nurse re-deployment across the Health Board. May 2022 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is ongoing to implement the programme.	On track
	22121	Implement Allocate Safecare system to all clinical areas and	Mrs Alison Griffiths,	30/09/2022	Ensure that Health Board has increased visibility of the Nursing	On track

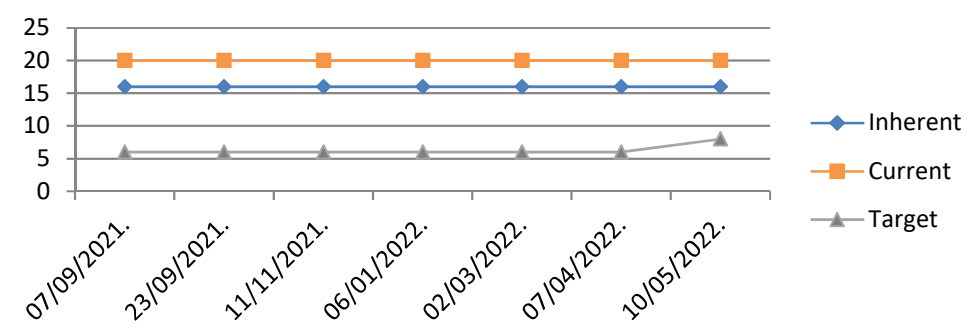
		associated training requirements.	Director of Nursing Workforce		workforce to ensure efficient utilisation of nursing staff and better identify areas of risk to enable appropriate mitigation at a local level.	
	22122	Refresh and update the Nursing Recruitment and Retention strategy	Mrs Alison Griffiths, Director of Nursing Workforce	30/06/2022	This will allow an integrated medium term plan to be developed and implemented to ensure nurse recruitment and retention better identifies and resolves nurse staffing challenges. May 2022 - There are actions being captured within the Workforce delivery plan including rotation, supervision and development opportunities.	On track
	23095	Develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	The infrastructure will enable the delivery of nursing workforce staffing and professional standards agenda/portfolio.	On track

CRR21-14	**Director Lead:** Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 10 May 2022
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 31 October 2023

This may be caused by the increased number of patients who are refusing admission or who have mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meets the legal framework).

This is due to the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for deprivation of liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.

This could lead to harm to patients from unlawful detention, increase in Court of Protection Activity (COP), which may result in greater operational pressures, and increase in financial cost, poor patient experience and reputational damage for BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022.	Unchanged		

Controls in place	Assurances
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health and Capacity Compliance Committee (MHCCC), Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory adult at risk training levels 2 and 3 is in place for Mental Health and Learning Disabilities (MHLD) and key departments. This increases compliance with process and legislation and supports the reduction of unlawful detention.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting.

4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a]. 5. Deprivation of Liberty Safeguards (DoLS) COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 7. Welsh Government interim monies has been utilised to increase physical capacity in and out of hours to support the process of identifying patients on wards that could potentially be unlawfully detained to prevent harm to patients.	4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the Safeguarding Governance and Performance Group reported into Welsh Government. 7. Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the Safeguarding Team, which is reported to the Mental Health and Capacity Compliance Committee.

Gaps in Controls/mitigations
1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not within BCUHB control. Training and guidance for 16/17 year olds has been developed until the statutory guidance is published. 2. New legislation and statutory guidance driven by the UK Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. Preparation and the implementation is dependent upon capacity, resource and expertise with the awaited revised code of practice. A business case has been approved as part of the Integrated Medium Term Plan 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score. 3. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. The increase in data reporting and supporting activity has supported the identification of risk and intervention. 4. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. Some multi-agency guidance and intervention has been developed as a result of new Legislation and national guidance, which is being overseen by the North Wales Safeguarding Boards and supports collaboration with partner agencies. 5. There is a lack of consistent training compliance rates across the Health Board. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the Deprivation of Liberty Safeguards Co-ordinator to wards noting the

timescales and legal duties. In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training.

Progress since last submission
1. Controls and Assurances reviewed to reflect current risk position. 2. Gaps in Controls reviewed to reflect current risk position. 3. Terms of Reference for Liberty Protection Safeguards Strategic Implementation Task and Finish group ratified and approved by Mental Health and Capacity Compliance Committee. 4. Date set for the inaugural Liberty Protection Safeguards Strategic Implementation Task and Finish group. 5. Integrated Medium Term Plan has acknowledged funding for additional resources, awaiting allocation and remains on reserve list for release in quarter 3. 6. Action ID 15708 - Action delayed, consultation completed, with governance approval following the Health Board's policy on policies. 7. Action ID 18117 - Action delayed with business case to be re-submitted to Executive team to support the release of monies from Quarter 3 22/23. 8. Action ID 18118 - Action delayed, consultation completed, with governance approval following the Health Board's policy on policies. 9. Action ID 20957 – Action delayed, due to UK and Welsh Government for release of code of practice, consultation due for July 2022. Anticipated due date for local implementation plan by end of August 2022. 6. Identification of new action ID 23066 to improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	15708	The Deprivation of Liberty Safeguards Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non compliance with legislation for the both the Managing	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business	31/10/2021	The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention. May 2022 progress - Action delayed, consultation completed, governance	Delay

		Authority and Supervisory Body.	Support Manager		approval following the Health Board's policy on policies is in progress.	
	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	Additional resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. May 2022 progress update - Action delayed with business case to be re-submitted to Executive team to support the release of monies from Quarter 3 22/23.	Delay
	18118	Implement and monitor a Court of Protection Engagement and Standard Operating Procedure for Deprivation of Liberty Safeguards / Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2021	The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the Court of Protection and meet the needs and safeguards of service users. May 2022 progress - Action delayed, consultation completed, governance approval following the Health Board's policy on policies is in progress.	Delay
	20957	Development of implementation plan in readiness for the receipt of the Mental Capacity Act – Liberty Protection Safeguards Code of Practice.	Michelle Denwood, Director of Safeguarding and Public Protection	31/05/2022	This will enable the organisation to be prepared for the receipt and implementation of the Liberty Protection Safeguards Code of Practice in the absence of a UK Government timeframe. May 2022 progress update - Delay due to UK and Welsh Government for release of the code of practice. Consultation had now commenced, end date is July 2022. Anticipated	Delay

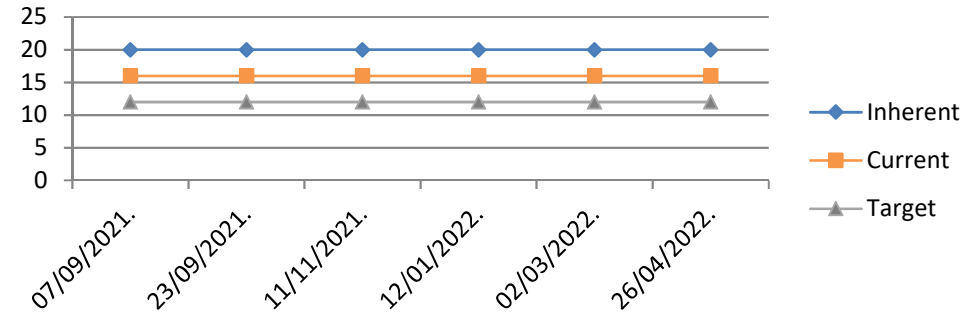
					due date for local implementation plan by end of August 2022.	
	21213	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan.	On track
	23066	Improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.	Michelle Denwood, Director of Safeguarding and Public Protection	30/11/2022	Welsh Government monies will support additional resource and educational tools to inform the workforce regarding capacity and harm which will reduce risk and improve patient care.	On track

CRR21-15	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 April 2022
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 31 October 2023

There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children/Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.

This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.

This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**

1. All Wales and North Wales Safeguarding procedures approved and in place. 2. BCUHB local work programmes in place and aligned to the national strategies which are regularly reported to Welsh Government. 3. Risk Management has been embedded into the processes of the reporting framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums agendas. 4. A standardised data report on key areas including Adult at Risk, Child at Risk and Deprivation of Liberty Safeguards (DoLS) is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms. 6. The BCUHB Children's Division are managing the recruitment process for the replacement of the named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor. 7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 8. Welsh Government interim monies has been utilised to increase physical capacity out of hours. 9. Sexual Abuse Referral Centre (SARC) lead has been identified for the Health Board to support the implementation and compliance against the SARC accreditation.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government.

Gaps in Controls/mitigations
1. The increase in safeguarding activity, with enhanced complexity as a result of COVID, and the increase in victims recognised as a result of Domestic Abuse and Sexual Violence, refugees, modern day slavery/Human trafficking and county lines, has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. This has resulted in the prioritisation of elements of service delivery aligned to the identified risk, being put in place. 2. The inability of safeguarding specialists to be in attendance at required meetings. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated.

3. The lack of a comprehensive digital clinical patient record reduces the identification of individual patient risks which results in the delay of information, communication and is time consuming. Safeguarding mandatory fields are in place within the Symphony system into Emergency Departments with alternative platforms in place when they have limited digital patient records.
4. Lack of consistent approach by the 6 Local Authorities in North Wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible.
5. Named Doctor Safeguarding Children - this post remains vacant. Currently working in conjunction with the Paediatric Team to ensure local arrangements are in place to support the Safeguarding agenda/portfolio.
6. Compliance rates of training does not provide assurance against the knowledge and application of the training into clinical practice. Measuring understanding and application of training materials using desktop reviews, audit and utilising a survey monkey is to be developed and monitored by implementation plan.

Progress since last submission

1. Controls in place updated to reflect current position with the identification of additional controls.
2. Assurance sources updated to reflect the addition of new controls in place.
3. Gaps in controls reviewed and updated to reflect current risk position.
4. Extension to the Target Risk Due date from the 01/04/2022 to the 31/10/2023 to allow time for organisational processes to be followed and to be able to fully implement organisational process and new statutory legislation using the agreed funding.
5. Action ID 18113 - The action remains delayed due to North Wales Safeguarding Board supporting a Welsh Government task group to review the position of trust procedure to support the development of regional procedures, this still causes a delay against internal BCU activity.
6. Action ID 18115 – Action closed due to the duplication with the Childrens Services Risk, also recognising that whilst the responsibility for the recruitment to the vacant post of Named Doctor Safeguarding, alternative actions are being put in place supported by Corporate Safeguarding to support the mitigation of this risk. This action will now be archived and removed from the next iteration of the report.
7. Action ID 18116 - Action remains delayed, however, the re-deployed staff for COVID management have now returned to the substantive posts which will support progress of the action. A single point of contact for BCU is now in place with estimated completion and approval of the Terms of reference expected by end of July 2022.

8. Action ID 18120 - Action delayed as The North Wales Safeguarding Board is developing a task and finish group to receive national documentation to support implementation and process across North Wales. Anticipated delay to this action due to the Home Office delayed agreement relating to process and information governance for domestic homicide reviews which are expected to be part of the unified review which is currently out of the Health Board's control, and negotiations are being led by Welsh Government.
9. Action ID 21217 – Action closed as reviews have been undertaken between the Paediatrician/Paediatrics and the Corporate Safeguarding Teams with consideration given to the future role of the named Dr for Safeguarding Children against safeguarding legislation and statutory duties. The responsible service for the recruitment of the post have advertised for the role. This action will now be archived and removed from the next iteration of the report.
10. The risk associated with safeguarding and public protection will remain high due to the likelihood of injury (physical, emotional, sexual and neglect) and the impact on individuals as a result of abuse or omission of care and/or criminal exploitation.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	18113	Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014].	Michelle Denwood, Director of Safeguarding and Public Protection	20/12/2021	The process and the development of Key Performance Indicators can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings.	Delay

					April 2022 progress update - North Wales Safeguarding Board are supporting a Welsh Government task group to review the position of trust procedure to support the development of regional procedures, this still causes a delay against internal BCU activity.	
	18115	Advertisement and Recruitment of the Named Dr Safeguarding Children/Children at Risk.	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business Support Manager	20/12/2021	ACTION CLOSED 31/12/2021, due to duplication with the Childrens Services Risk. Ensure full compliance with legislation and ensure clinical strategic and operational safeguarding responsibilities are met. To support the mitigation of the actual risk, the Safeguarding Team are working in conjunction with the BCUHB Consultant Community Paediatricians to provide an alternative solution until the vacancy can be filled. Therefore a further action is taking place to review current and future role and	Close

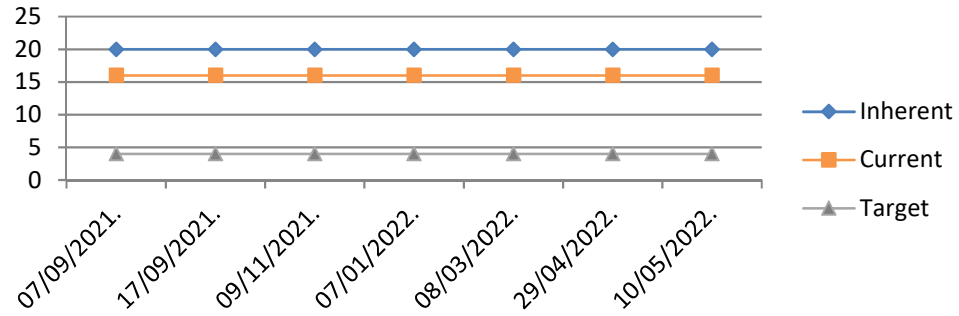
					responsibilities. See action 21217. Action closed taking the above duplication and alternative actions / mitigations being put in place.	
	18116	To Implement and monitor strengthened governance and reporting pathways for Sexual Assault Referral Centre.	Michelle Denwood, Director of Safeguarding and Public Protection	10/01/2022	Compliance with legislation and early identification of risk and harm. April 2022 progress update - Action remains delayed, however, the re-deployed staff for COVID management have now returned to the substantive posts will support progress of the action. Identified lead for SARC accreditation has been moved and is now the responsibility (as of February 2022) of the Corporate Safeguarding Team for the Health Board. As a result links have been strengthened with the Welsh Government national SARC lead and North Wales Police project lead (North Wales Police who hold the legal entity for this activity). Implementation plan has been developed and the	Delay

					implementation of a SARC steering group will monitor progress. A single point of contact for BCU is now in place with the development of a Project Board, the estimated completion and approval of the Terms of reference is expected by end of July 2022.	
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	The revised procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of Organisational risks. April 2022 progress update - The North Wales Safeguarding board is developing a task and finish group to receive national documentation to support implementation and process across North Wales. Anticipated delay to this action due to the Home Office have delayed agreement relating to process and information governance for domestic homicide reviews which are	Delay

					expected to be part of the unified review which is currently out of the Health Board's control and negotiations are being led by Welsh Government.	
	21216	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. April 2022 progress update - Intermediate Medium Term Plan and the additional funding identified is now on the reserve list, with planned streamline of the Business case to support a total review of the Safeguarding structure.	On track
	21217	Review current and future Paediatrician role and responsibility to comply with Safeguarding legislation.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2022	Ensure roles and responsibilities meet Safeguarding legislation requirements both operationally and strategically. Working in conjunction with the BCUHB Consultant Community Paediatricians.	Completed

					March 2022 progress update - Reviews have been undertaken between the Paediatrician/Paediatrics and the Corporate Safeguarding Team with consideration given to the future role of the named Dr for Safeguarding Children against safeguarding legislation and statutory duties. The responsible service for the recruitment of the post have advertised for the role. Action closed.	

CRR21-16	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 May 2022
	Risk: Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 20 June 2023
There is a risk that insufficent Manual Handling training could lead to staff and patient injury, lost work time, Health and Safety Executive enforcement action (recent related Improvement Notices for Patient Falls, Patient Handling and Portering Load Handling risk assessments) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff. This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	1	4
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	Assurances
1. Health & Safety Strategy has been approved and implemented which includes Manual Handling. 2. Training work programme is in place specifically in relation to Manual Handling. 3. Recruitment programme has been approved and is in place as part of the Health & Safety business case. 4. Risk assessments in place to provide safe training environment.	1. Regular oversight and review by the Occupational Health & Safety Team. 2. Reviewed at the Strategic Occupational Health and Safety Group.

5. Two year training plan in place which will cover delivery of training and current shortfalls in training. 6. A full review of the training was completed in August 2021 to ensure the training provided was in line with the All Wales Manual Handling training passport scheme.	3. Risk Management Group oversight. 4. Local Partnership Forum. 5. Health and Safety Executive inspections.

Gaps in Controls/mitigations
1. Although the training programme is in place there is currently a national shortage of manual handling trainers. Re-advertisement for posts is continuing. 2. Low compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance. 3. Lack of integrated booking system with the ESR system and ESR is not easy to use. Manual bookings currently in place. 4. Did Not Attend (DNA) at training sessions. A review of the rate of DNAs and evaluation of causes of none attendance remains gap in the system. This will be undertaken by the new band 6 roles, when in post. This will strengthen the review of DNA's as part of the work programme. 5. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the Manual Handling Passport Scheme. The business case has been agreed and is being implemented for two years but this remains a gap in the controls until recruitment has been successful. Current compliance for Patient Handling refresher is now at 49%. 6. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments, Action plan has been incorporated and the HSE verified compliance.

Progress since last submission
1. Risk Description updated to reflect current risk position so that the risk is more clearly articulated. 2. Controls in place reviewed and updated to reflect current risk position. 3. Gaps in controls reviewed and updated to reflect current risk position and updated in relation to the reduction in current compliance for Patient Handling refresher training from 55% to 49%. 4. Health and Safety Team are preparing for a visit from the Health and Safety Executive due 18 May 2022 to carry out an inpatient manual handling risk assessment and patient falls risk assessment review. 5. Action ID 17978 – Action closed, premises on all 3 regions now secured, and fully functional. IT infrastructure is now in place. 6. Action ID 17979 - Action remains delayed, interviews for the Manual Handling Manager posts held, they are due to start 01 August 2022. Further adverts for the vacant band 6 Manual Handling Trainer/ Adviser posts will be out by the end of May

7. Action ID 17980 – Extension to the action due date from the 31/12/2021 to the 01/04/2023 to allow sufficient time for the training provision to reach an acceptable level in line with the action plan to be presented to the Health and Safety Executive. Action plan presented to the Health and Safety Executive on the 14th March 2022 with details on how the training will be focused within the Health Board. HSE approved the response and the notice was complied with.
8. Action ID 18859 – Action remains delayed. Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 September 2022.
9. Action ID 18860 – Action closed as Patient Falls Training Modules 1A and 1B are now available on the ESR system.
10. Targeted intervention training trialled within 2 areas on the East and Central sites, with subsequent roll out of the training within 4 areas of the Wrexham site currently ongoing.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	17978	Renting of temporary training rooms in West, Central & East. Report has been approved for 2 year leases on the premises, awaiting contracts to be finalised.	Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security	30/11/2021	Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing and increasing the number of courses that can be delivered, increase the number of staff trained and increase compliance for BCUHB. April 2022 progress update - Premises on all 3 regions now	Completed

					secured, and fully functional. IT infrastructure is now in place.	
	17979	Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security	30/11/2021	Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB. April 2022 progress updates - Interviews for the Manual Handling Manager posts held, references received with start date of the 01/08/2022. Band 6 Manual Handling training posts will be re-advertised by the end of the month.	Delay
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security	01/04/2023	Progress update - Extension of the action due date from the 31/12/2021 to the 01/04/2023 to allow sufficient time for the training provision to reach an acceptable level in line with the action plan to be presented to the Health and Safety Executive. Action plan has	On track

					been presented to the Health and Safety Executive on the 14th March 2022 with details on how the training is to be focused within the Health Board. Targeted training on patient falls and handling risk assessments has commenced on 4 areas on the Wrexham site. The porters load handling risk assessments have been revised to include TILE. Supervisors have been re-trained on risk assessments and particularly load handling risk assessments. All porters to be given information, instruction and training on the risk assessments. An audit programme has commenced for both patient falls and patient handling risk assessments.	
	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mr Peter Bohan, Associate Director Of	31/12/2021	Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the	Delay

			Occupational Health Safety and Security		likelihood of injury to both patients and staff. April 2022 progress update - Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 September 2022.	
	18860	ESR to be reviewed to include the patient falls 1A and 1B training courses for inanimate load level 1.	Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security	31/03/2022	Support the risk and allow correct compliance and correct level of training, reducing the risk of injury for those attending class for a competency assessment. Completion of the patient falls risk assessment template is trained by the Manual Handling team along with the Patient Handling template. Action closed as Patient Falls Training Modules 1A and 1B are now available on the ESR system. Workbooks have also been created for use by staff, under manager supervision,	Completed

					who have limited access to computers.	

<table>
<tr><td rowspan="3">CRR21-17</td><td>Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services</td><td>Date Opened: 26 July 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 12 May 2022</td></tr>
<tr><td rowspan="2">Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.</td><td>Date of Committee Review: 01 March 2022</td></tr>
<tr><td>Target Risk Date: 31 October 2022</td></tr>
<tr><td colspan="3">There is a risk that Young people attending Emergency Departments, Paediatric wards in crisis and out of hours with suicidal behaviour/ideation, actual self-harm and those detained out of hours under a s136 may not always receive timely access to Child and Adolcent Mental Health Services (CAMHS) to ensure highest quality patient-centred care.

This may be caused by a number of contributory factors, the list below is not exhaustive:
• Current operational hours of CAMHS is 9am-5pm over 7days a week.
• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.
• increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
• crisis presentations to the Emergency Departments with associated social care placement breakdowns leading to young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.
• awaiting a CAMHS Tier 4 bed following a mental health assessment.

The environments within the Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered, age appropriate they are also not designed to meet this type of need within their environments.

This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.</td></tr>
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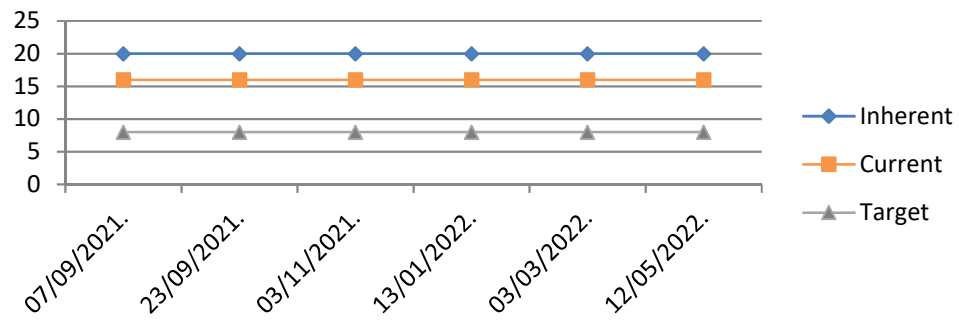


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022	Unchanged		

Controls in place	**Assurances**
1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Area Team. 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Area Teams as part of the risk assessment and risk management processes. 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. 4. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 7. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 9. Safeguarding discharge Standard Operating Procedure for young people in place.	1. A scoping exercise or report of Child and Adolescent Mental Health Services (CAMHS). Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB approach. 3. Risk also regularly discussed at the Area - Quality and Safety Group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with Welsh Government, joined with Mental Health Division on a quarterly basis.

10. Daily situation report (SITREP) reporting between Paediatrics and CAMHS, which includes incident notifications. 11. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff, which has been exacerbated by the lockdown arising from Covid-19. Currently working with recruitment agency and established multi-disciplinary team is already in place. 2. Lack of suitable Local Authority placements or shared safe environments within which young people can be assessed or discharged to. Looking and considering alternative safe environments/accommodation across all health economy areas and Local Authority partners. 3. Lack of agreed consistency, threshold and standardisation for reporting related incidents across the Health Board in relation to Mental Health patients on Paediatric wards. Incidents are being reported within areas and reviews are undertaken at Child and Adolescent Mental Health Services (CAMHS) and paediatric safety meetings.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. In line with the new Operating Model the Executive Director has been amended. 4. Bid submitted for Executive approval, if supported will be presented to Welsh Government for Mental Health improvement funding for alternatives to admission to provide safe place to pilot across all 3 health communities. 5. Action ID 17961 – Action closed due to risk assessments from all 3 regions having now been received 6. Action ID 17962 – Action closed with the successful commissioning of the “Just R” recruitment and ongoing campaign. Wider workforce strategy is in development under the targeted intervention programme. 7. Action ID 17963 - Action remains delayed, consultation ongoing with NICE from 18/01/2022 to 01/03/2022 expected publication date 06/07/2022. Draft Operational Standard Operating Procedure for BCU has been updated and currently being reviewed by clinicians to ensure clarity on roles and responsibilities whilst BCU awaits the new guidance. 8. Action ID 17964 – Approve the extension to the action due date from 31/03/2022 to 31/10/2022 to allow sufficient time for the development and implementation of the action. Following review of the training requirement, it was identified that there is a need

for the development of an ongoing training programme rather than one off training sessions, therefore this will require some scoping and resourcing.
9. Action ID 19594 - Action remains delayed, currently liaising with the Heads of Nursing in Central and West area to progress the action following the pause in December/January due to Covid 19.
10. Action ID 19595 – Action closed as completed, incidents reviewed and now included within daily Sit Reps.
11. Identification of new action ID 23091 to progress with recruitment to bespoke campaign for Child Psychiatry.

Links to	
Strategic Priorities	**Principal Risks**
Improved Unscheduled Care pathways Integration and improvement of Mental Health Services	BAF21-01 BAF21-08

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways. Progress - Draft currently being circulated for final comments prior to approval at	On track

					the BCUHB Regional Children's Services Group and Together Mental Health Partnership Board.	
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing Child and Adolescent Mental Health Services (CAMHS).	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/10/2022	This will enable us to meet the needs of young people before crisis occur as most of their needs are pyscho-social and not just Mental Health. Progress - Draft currently being circulated for final comments prior to approval at the Childrens Sub Group of the Regional Partnership Board and Together Mental Health Partnership Board.	On track
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	29/10/2021	ACTION CLOSED 13/01/2022 Ensure a safe environment by identifying all ligature points on the ward. Ligature point assessments received from East, West and Central.	Completed
	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/03/2022	ACTION CLOSED 31/03/2022 It will support timely access to support and treatment in relation to the demand that	Completed

					has been experienced. The increase in workforce will enable us to provide more out-of-hour response. Progress update - Action closed with the successful commissioning of the “Just R” recruitment and ongoing campaign. Wider workforce strategy is in development under the targeted intervention programme.	
	17963	Task and Finish Group to review SCH03 Policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	30/12/2021	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions. Progress update - Action remains delayed, consultation ongoing with NICE from 18/01/2022 to 01/03/2022 expected publication date 06/07/2022. Draft Operational Standard Operating Procedure for BCU has been updated and currently being reviewed by clinicians to ensure clarity on roles and responsibilities	Delay

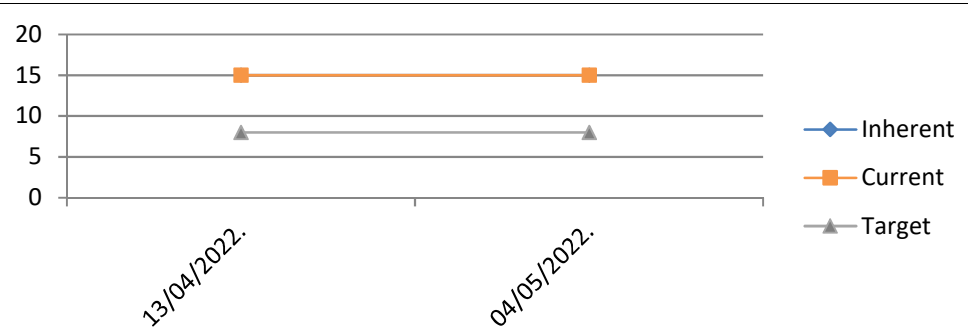
					whilst BCU awaits the new guidance.	
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ Emergency Department staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/10/2022	Create awareness and develop skill in assessment and improve staff morale. Progress update – Extension to the action due date from 31/03/2022 to 31/10/2022 to allow sufficient time for the development and implementation of the action. Following review of the training requirement, it was identified that there is a need for the development of an ongoing training programme rather than one off training sessions, therefore this will require some scoping and resourcing.	On track
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital. Progress to date - Safe space pilot to take place from the 31/1/2022 in the East area operating over 3 evenings with access to various specialties. In the process of arranging	On track

					dates for the West area for conversation on how to take a similar pilot forward.	
	19594	Develop a programme of auditing risk assessments as part of the admissions pathways on a quarterly basis.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	01/02/2022	The Risk Assessment and audit process will support the reduction in the risk score whilst recognising that the paediatric wards cannot be a completely ligature free environment. Progress update - Action remains delayed, currently liaising with the Heads of Nursing in Central and West area to progress the action following the pause in December/January due to Covid 19.	Delay
	19595	Further analysis of the incidents reported in order to determine what further actions are required to ensure appropriate reporting of the incidents.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/01/2022	ACTION CLOSED 31/01/2022 Provides a greater understanding of the incidents occurring and the measured required to be put in place to support both staff and patients and supports a safer environment.	Completed

					Action closed as completed, incidents reviewed and now included within daily Sit Reps.	
	21236	Implementation of recommendations following the Delivery Unit Crisis Care Review.	Marilyn Wells, Head of Nursing / CAMHS Clinical Lead	31/10/2022	Provide further assurance following a review by an external body and the implementations of any recommendations to support the development of high quality and safe care. Progress update - Verbal feedback received in relation to the action, formal report remains awaited.	On track
	23091	Progress with recruitment to bespoke campaign for Child Psychiatry.	Mrs Louise Bell, Assistant Area Director	31/10/2022	Implementation will help to deliver a safe and sustainable service within BCU.	On track

CRR22-18	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 10 December 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 04 May 2022
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** New Risk
		Target Risk Date: 31 March 2024

There is a risk that Infection Prevention (IP) will not be able to provide an effective service to BCUHB. This may be caused by the relative limitations in size of the service (taking the size of the Health Board into account) and the current significant unfilled vacancies.
This could lead to an increase in healthcare associated infections, patient harm and loss of reputation to the organisation.



	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. 2. Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 3. Reviewing and prioritising the programme of work and workloads for all staff in the team e.g. ensuring experienced Infection Prevention nurses are not doing admin tasks. 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which Infection Prevention risk is lower. 5. Reviewing and prioritising attendance at meetings and on groups etc. 6. Employed senior manager via an agency to support the team. 7. Supporting and protecting existing team with measures including weekly team meetings and reviews.	1. Infection Prevention Audits reported at local groups and to the Infection Prevention Sub Group. 2. Alert organism statistics. 3. Compliance with Welsh Health Circular 2021 Number 028 reported to Infection Prevention Sub Group and to Quality Safety and Experience Committee. 4. Patient incident reviews. 5. Regular review of Datix Incidents which are alerted to the team when logged on the system, for learning purposes and for rectification. 6. Outbreaks are monitored, managed and reported to Infection Prevention Sub Group.

	7. Regular review of Infection Control and Prevention trajectory reported at Local Infection Prevention Groups. 8 Risk regularly reviewed at Infection Prevention Sub Group.

Gaps in Controls/mitigations
1. There is a national issue recruiting into Infection Prevention and Control roles, particularly at a senior level (7s and above). Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 2. Experienced Infection Prevention Agency nurses only want to work remotely. Staff members working remotely are required to review policies produce reports which in turn releases non-remote working staff to undertake clinical work. 3. The 2 vacant band 8bs have been advertised but there were no suitable applicants. Post re-advertised and currently cross covering within the service with Senior members of the Infection Prevention team (IP) providing support to other areas as well as their own.

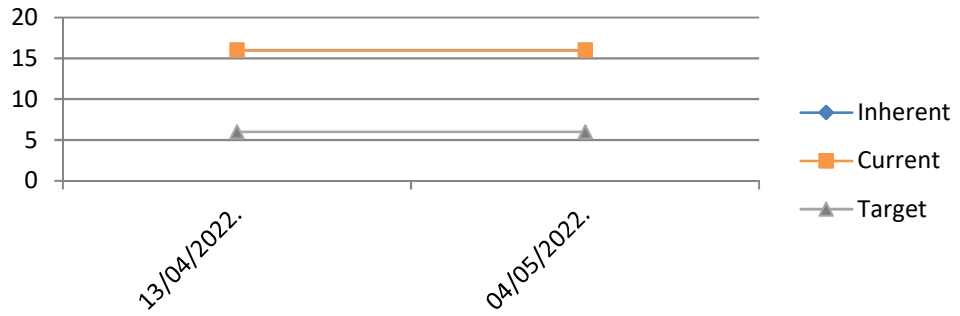
Progress since last submission
1. Controls in place reviewed and strengthened to align with current risk position. 2. Gaps in controls reviewed and updated to align with current risk position. 3. Contacted international nurses - 4 have been interviewed to date and have been asked to apply for vacant posts once advertised. 4. An experienced Infection Prevention nurse known to the Director of Infection Prevention now in post from an agency part time for 6 months. 5. New SBAR completed and approval given to refresh the band 8a job description used in the past and then advertise for band 8as. 8c (and 8b) will then provide additional support to help them develop and some of their work will be picked up by the agency nurse in point 4. 6. Working wherever possible as one Infection Prevention team as opposed to three, to allow experienced Infection Prevention nurses to support remotely across the sites and increase junior staffing to increase visibility of band 4's and band 6s. 7. Trajectory for C. difficile has improved over the past 6 months and the Health Board now has the lowest rate of all Health Boards across Wales.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-09

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	20654	Use Infection Prevention Champions to promote good practice.	Mr Dafydd Williams, Infection Prevention Nurse	30/09/2022	To help promote Infection Prevention in their own departments whilst visibility of the Infection Prevention team will be low.	On track
	20659	Business case for expanding current team.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	To outline case to the Executive that more staff are required and obtain approval for funding.	On track
	21696	Recruit to current vacant Infection Prevention posts.	Mrs Andrea Ledgerton, Specialist Matron Infection Prevention	30/09/2022	Fill current vacant posts.	On track
	21698	Work with Communications and Workforce to develop a Recruitment Campaign for Infection Prevention nurses.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To help attract Infection Prevention staff to BCU.	On track
	21702	Draw up a development programme and a succession plan to ‘grow our own’.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	29/07/2022	To develop own Infection Prevention staff and support recruitment and retention.	On track
	22927	Promote Infection Prevention Massive Open Online Course education programme.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/09/2022	To improve knowledge, practice and compliance with IP in wards and departments.	On track

CRR22-19	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 February 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 04 May 2022
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** New Risk
		Target Risk Date: 31 March 2024

There is a risk that medical equipment will not be decontaminated appropriately. This is caused by a number of factors including:
1. Sterile service departments air handling units require upgrade/replacement, some equipment and the track and trace system requires replacement and at WM hospital the steam generation plant and electrical infrastructure requires an upgrade.
2. Poor, outdated facilities for decontaminating dental equipment, scopes and probes, and washer disinfectors at YGC and WM in endoscopy are at end of life. Also they rely on a paper track and trace system.
3. There is a lack of robust approved SOPs for decontamination.
This could lead to transmission of infection, vital treatments and services having to stop, patient complaints and litigation, enforcement action, improvement notices, multiple breaches in statutory duty, critical reports and adverse media coverage.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. Decontamination audits have been increased to twice yearly. 2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units. 3. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning. 4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board. 5. Single use scopes are being used where possible removing the requirement for decontamination. 6. Engineering support is presented from the in-house facilities team and is generally to a high standard.	1. Regular review by Decontamination Group. 2. 6 monthly decontamination audits by Infection Prevention team. 3. Decontamination audits by Authorised engineers. 4. Sterile services departments have audits carried out by notified bodies in accordance with the Medical Device Directives/Regulations. 5. Risk register on decontamination.

7. Governance systems are managed by the Authorised Persons (Decontamination). 8. The Executive Director for Infection Prevention has been alerted and requested an overall risk assessment. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership.	

Gaps in Controls/mitigations
1. The Decontamination Advisor currently on a period of extended leave. Staff member currently acting up into the position to cover this period. 2. Some Consultants do not want to use single use scopes – rep coming in to discuss with them. 3. There are not many risks on Datix related to Decontamination and there is inconsistency in scoring e.g. one site has a risk related to track and trace in Sterile Services and Disinfection Units scoring 10, another scores it 4. There needs to be review of all risks relating to Decontamination and updates requested from de-contamination group members. 4. Potential disruption to the safe delivery of decontamination service due to the ageing equipment and estate is being mitigated against by establishing contingency plans.

Progress since last submission
1. Controls in place reviewed and strengthened to align with current risk position. 2. Gaps in controls reviewed and updated to align with current risk position. 3. Agencies have been contacted for a Decontamination Specialist advisor to work for BCU for minimum of 3 months. However, due to no suitable candidates, internal team member currently acting up to the role. 4. Single use scope representative has attended all acute sites to update Consultants on the latest technology available. 5. Request made to Shares Services to carry out a review of the decontamination infrastructure in Sterile Services departments to identify priority areas. Anticipated review by July 2022. 6. Action ID 23024 - New action identified to seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-02 BAF21-09

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status

Actions being implemented to achieve target risk score	22146	Revise and approve the Decontamination group terms of reference.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/06/2022	To ensure appropriate and robust membership of the group and a process of monitoring and continual improvement. Terms of reference drafted and awaiting approval by Infection Prevention Sub Group.	On track
	22147	Policies and Standard Operating Procedures written/revised and approved for Decontamination.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	As part of good governance and so staff are aware of their responsibilities and roles and how to decontaminate medical devices. The action will focus on policies and procedures due for review by the end of 2022.	On track
	22148	Purchase new washer disinfector for endoscopy unit at Ysbyty Gwynedd.	Mrs Joanna Elis-Williams, Head of Secondary Care Office	31/08/2022	To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated.	On track
	22149	Meet with key stakeholders re scope issues at Ysbyty Glan Clwyd and Wrexham Maelor.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/07/2022	To highlight key issues and establish a way forward.	On track
	22152	Community Dental Services, Assets and Facilities group to reform and form a plan for moving forwards.	Peter Greensmith, Business Support Manager - Dental	31/03/2023	To establish formal timeframe and funding for plans.	On track
	22153	Estates to meet with sterile services managers.	Mr Arwel Hughes, Head of	30/09/2022	To revise risk assessments and make plan for upgrading Sterile services departments.	On track

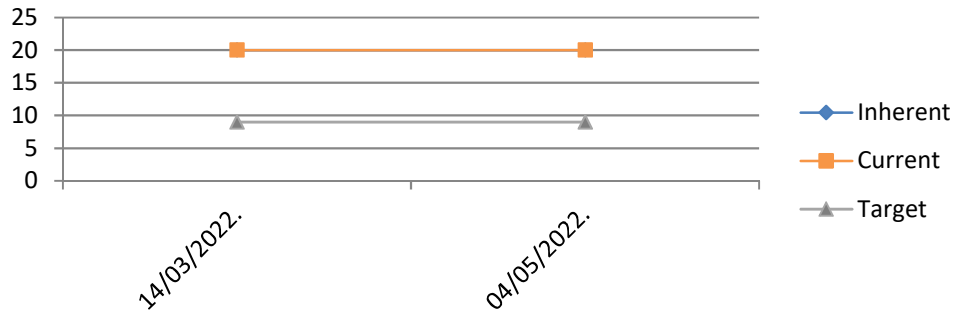
			Operational Estates - Interim		Action will take place following a review by Shared Services to identify priority areas, anticipated by July 2022.	
	22931	NHS Wales Shared Services review of Sterile Services and Disinfection Units.	Mr Arwel Hughes, Head of Operational Estates - Interim	31/07/2022	To outline the specific risks and help BCU identify priorities.	On track
	22932	Carry out an audit of decontamination of all ultrasound machines and the use of ultrasound gel.	Sandra Lorraine Jones, Decontamination & IP Sister	30/06/2022	To ensure machines are being decontaminated appropriately and sterile gel is being used where indicated to reduce infection risks.	On track
	23024	To seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To demonstrate the improvement and high standards achieved by Endoscopy at the Unit.	On track

CRR22-20	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 04 May 2022
	Risk: There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinants	**Date of Committee Review:** New Risk
		Target Risk Date: 31 December 2025

There is a risk that residents in North Wales may be unable to achieve a healthy weight and may become overweight and obese.

This may be caused by behaviours involving food intake, current circumstances, lack of physical activities, the living environment, food production and consumption, socio-economic factors and a lack of engagement with health professionals.

This may have an impact on or lead to unhealthy weight and obesity and place them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. Continue to take a life course approach to implementing prevention based healthy weight initiatives which will report progress via a number of routes including the Healthy Weight Healthy Wales National Group, the BCU Population Health Group, and the Regional Partnership Group. 2. The continuation and further targeted development of 'Healthy Start' which provides vouchers for pregnant women and eligible families to buy milk, fruit, vegetables and pulses in local shops. 3. Continuation and further development of Maternity and Healthy Visiting Services supporting breastfeeding and weaning to support the Infant feeding Strategy, monitored via the North Wales Strategic Infant Feeding Group. 4. Community Dietetics Services will work with childcare provision embedding 'Tiny Tums' programme across all Early Years settings to encourage healthy, nutritious eating habits from early years.	1. Building a Healthier Wales Programme and Healthy Weight Healthy Wales Programme (both nationally funded). 2. Reporting progress to National team (Public Health Wales/Welsh Government/Regional Partnership Board). 3. Progress on mitigating and managing risks reviewed locally via the Public Health Team and Health Improvement

5. Further supporting schools to take a 'whole schools' approach to health and wellbeing with a particular focus on diet through initiatives such as Come and Cook with your child and considerations regarding developing healthy eating habits and increased physical activity. 6. Lets Get Moving North Wales - a continuing programme encouraging residents of North Wales to move more often will operate alongside Sport North Wales, physical literacy development in schools and communities. 7. Continue to support the workforce to make healthy choices such as a balanced diet, active travel and moving more often through targeted campaigns and supportive services/infrastructure. Working with catering, dieticians, estates and occupational health colleagues to contribute to planning which considers these factors. 8. Further develop the whole system partnership approach to tackle risk factors through influencing priorities such as environmental planning and design, access to healthy food and active travel. 9. Further develop the links and access to Social Prescribing that encourages physical activity through partnership working with Primary Care, Local Authorities and Third Sector. Developing North Wales planned approaches and accessing intelligence regarding access and uptake via the Elemental software. Progress will be reported via the Population Health Group, Primary Care groups and via the Well North Wales Programme (including Partner organisations).	and Reducing inequalities Group (chaired by DoPH). 4. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

Gaps in Controls/mitigations
1. The risk requires System-wide approach to tackling the wider determinants of health. 2. The current Health Board provision is not operating at scale to meet the current and forecast needs of the population. 3. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	22372	Whole system approach to healthy weight.	Teresa Ann Owen, Executive Director of Public Health	31/03/2025	Taking a whole system approach to healthy weight will ensure that all partners are prioritising the issue of healthy weight and considering the impact of their decision-making on the populations' ability to achieve a healthy weight. Obesity is a complex multi-factorial problem that requires a whole system approach. Key partners that are crucial to this work include spatial planners, transport providers, education providers, food providers, leisure providers etc.	On track
	22373	Healthy Choices in the workplace.	Teresa Ann Owen, Executive Director of Public Health	31/03/2023	The working age adult population spend a significant amount of their time in the workplace. As a result it is crucial that we support workplaces to be health promoting. This means ensuring staff have access to healthy food choices, equipment to make healthy meals, enough time away from work to prepare and eat a healthy meal. It is also crucial that the workplace supports their staff to remain active while at work as both diet and physical activity are crucial to achieving a healthy weight.	On track
	22374	Spatial planning and public health.	Teresa Ann Owen, Executive Director of Public Health	01/09/2022	The environment that we live in has a significant impact on our health and wellbeing. A range of factors that impact on obesity are within the control of spatial planners including, the number of food outlets in an	On track

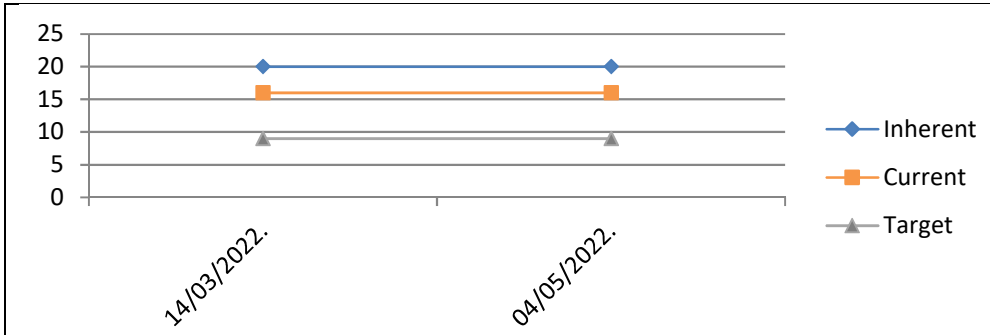
					area, the design of homes we live in, the design of roads to enable active travel (pavements for walkers and cycle paths for cyclists). Having access to green spaces and play environments are crucial to ensuring people are given opportunities to remain active. Working with spatial planners to understand this and their role in taking a public health perspective across their work is crucial to reducing obesity.	
	22375	Social prescribing.	Teresa Ann Owen, Executive Director of Public Health	01/11/2022	Increasing physical activity levels is crucial in supporting people to achieve and maintain a healthy weight. One way that we can support people to do this for free is by promoting access to the natural environment. By doing this will also improve people's mental health as well as their physical health. This approach will also develop peoples appreciation for nature and the need to protect it. One way of doing this is to optimise access through social prescribing.	On track
	22376	Pre-diabetes programme.	Teresa Ann Owen, Executive Director of Public Health	31/03/2025	By identifying patients who are at risk of developing diabetes and supporting them to access specialist weight management services we are taking a teachable moment opportunity and ensuring the patient is supported to improve their health and wellbeing. Primary care brief interventions are crucial in motivating people to change by implementing this programme	On track

					across North Wales it is hoped more of the population who are overweight or obese will seek support to achieve and maintain a healthy weight.	
	22377	Weight management services.	Teresa Ann Owen, Executive Director of Public Health	31/03/2023	By ensuring those residents in North Wales who are overweight or obese can effectively access and engage with specialist weight management services working alongside the remaining whole system approach we will start to reduce the overall prevalence of overweight and obesity in North Wales.	On track

CRR22-21	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 04 May 2022
	Risk: There is a risk that adults who are overweight or obese will not achieve a healthy weight due to engagement & capacity factors.	**Date of Committee Review:** New Risk
		Target Risk Date: 31 December 2025

There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to non-engagement with services or demand for services exceeding capacity.

This could impact on the health outcomes for these individuals by placing them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Healthy Weight Healthy Wales funding to support with the implementation of the All Wales Adults Weight Management Pathway. 2. Additional investment in Foodwise for life for those residents with a BMI of 25-35. 3. The establishment of Level 2 weight management services through Foodwise for residents with a BMI of 25-35 and Slimming World vouchers for residents with a BMI of 30-35 with certain health conditions. 4. The establishment of a Level 3 weight management service KindEating programme for residents with a BMI of between 35-45. 5. Investment in dedicated obesity leads within each of the LA National Exercise Referral programmes. 6. The establishment of a BCU Healthy Weight Healthy North Wales group to oversee the delivery of specialist weight management services.	1. Building a Healthier Wales Programme and Healthy Weight Healthy Wales Programme (both nationally funded). 2. Reporting progress to National team (Public Health Wales/Welsh Government/Regional Partnership Board). 3. Progress on mitigating and managing risks reviewed locally via the Public Health Team and Health Improvement and Reducing inequalities Group (chaired by DoPH). 4. Work plans are reflected in Health Board Annual Operating Plan, Living

	Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements. 2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	22357	Insight work.	Steven Grayston, Assistant Area Director of Therapies (Central)	31/03/2023	Insight work will enable us to improve outcomes for patients who were identified as overweight or obese. factors that will be considered will include how patients access services, the intervention they receive and the factors that led to then disengaging. This information will allow us to design our weight management services to meet the needs of patients achieve better outcomes i.e. patients achieving a healthy weight and adopting healthy behaviours	On track

	22358	Pregnancy weight management service.	Steven Grayston, Assistant Area Director of Therapies (Central)	31/12/2023	providing a weight management service during pregnancy will ensure that women are able to achieve a healthy weight during and after pregnancy and maintain their healthy behaviour postnatally.	On track
	22359	Performance management dashboard.	Steven Grayston, Assistant Area Director of Therapies (Central)	31/03/2023	Developing a performance management dashboard will ensure that we are able to monitor the uptake of the service by population groups that are at increased risk of adverse outcomes from obesity. The dashboard will enable us to monitor both uptakes and outcomes by ethnicity, gender and deprivation decile.	On track
	22943	Implement Healthy Weight Healthy Wales Programme Plan.	Steven Grayston, Assistant Area Director of Therapies (Central)	31/03/2024	Funded activity targeted at improving healthy eating habits and tackling obesity.	On track

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19 May 2022
	Risk: Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** New Risk
		Target Risk Date: 30 September 2022

There is a risk that BCUHB staff cannot access their mandatory resuscitation training.

This is due to several factors including:
A lack of 'fit for purpose' training accommodation and equipment across the sites; Insufficient numbers of Resuscitation Officers/Trainers.

This could lead to failure to deliver effective patient care resulting in preventable harm or death from impaired or unsuccessful resuscitation.
Additional risk of financial claims against BCUHB resulting from preventable harm/deaths.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	1	4
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. Resuscitation Policy and Guidance is in place for the Health Board with compliance overseen by the Resuscitation Committee. 2. Training plan in place governed by the UK core skills framework. 3. Resuscitation training is a mandatory training programme across the Health Board. 4. Delivery of the training has been re-designed to increase capacity, this has resulted in the reduction of clinical staff's time away from clinical duties. 5. Systems and processes are in place to manage attendance at training sessions.	1. The risk is reviewed monthly by the Resuscitation Services Senior Management Team, and is presented to the Resuscitation Committee on a quarterly basis. 2. Training figures and capacity are regularly reviewed on a quarterly basis at the Resuscitation Committee via site reports. 3. The risk has been presented to Performance Safety & Quality (PSQ), and

	Clinical Effectiveness groups (13th October 2021).

Gaps in Controls/mitigations
1. Despite controls above, there remains a deficit of approximately 2000 training places per year for resuscitation training at UKCSTF Level 3 on the Central locality. 2. There is no designated training accommodation on the Central locality. This lack of accommodation is in breach of the national standards as set by the Resuscitation Council UK. Continued breach could result in loss of course centre license on the Central locality which would cease all level 3 training from the site. The identified potential accommodation requires approximately £136k to make safe and fit for purpose and there is currently no identified funding source. Identification of this funding source has been asked for from Central Site Management with support from Estates / Planning / Finance teams. 3. With particular relevance to the Ockenden report is the Newborn Life Support (NLS) provision which is running on limited capacity both East and West, and is at 0% capacity in central with no NLS training at all due to the lack of availability of suitable training accommodation. 4. The Audio-Visual system required for these courses is failing on the East site. In May 2022 two of the systems failed during the delivery of an Advanced Trauma Life Support course, which required those rooms to run without these resources for the remainder of the course. This impeded the course delivery and will feature in the course report from the course director to the Royal college of Surgeons. The failure of the AV system will impact on every course run in the East venue and requires replacement.

Progress since last submission
1. Controls in place updated to reflect current position 2. Gaps updated to reflect current position. 3. Actions updated to reflect current position.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Strengthen our wellbeing focus Primary and community care Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-04 BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	19313	Provision of permanent and fit for purpose training and office accommodation on the YGC site.	Mrs Sarah Bellis Hollway, Resuscitation Services Manager	30/09/2022	While it will not mitigate the clinical absence of Resuscitation Officers from the acute site, or loss of other non-training activity; the identification of a suitable commercial venue in which we can provide all levels of resuscitation training, along with F&P funding approval will lower the score in relation to training from 20 to 4 in the short term (lease period). This will mitigate the risk until a permanent venue within the YGC footprint is developed" Progress to date - Discussion ongoing with YGC site management.	On track
	23207	Allocation of training room in West to support Central site with ILS/pILS training as a short term.	Mr Christopher Glyn Shirley, Resuscitation Officer	30/06/2022	The action will enable us to mitigate and manage this risk by delivering training in the short term.	On track
	23208	To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues.	Ms Jane Woollard, Director of Nursing	30/06/2022	This action will enable a building to be secured for delivering training on the Centre Site thereby helping mitigate and manage this risk in the long-term.	On track

CRR22-23	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 02 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 April 2022
	Risk: Inability to deliver safe, timely and effective care	**Date of Committee Review:** New Risk
		Target Risk Date: 09 January 2024

There is a risk that patients attending Emergency Department (ED) would not be able to receive timely, safe and effective care. This is caused by overcrowding and reduced physical capacity to accommodate patients awaiting specialty beds (Medicine/Surgery).
This could lead to delay/inability to triage new attendants within 15 minutes of arrival as per national recommendations, deterioration in health/condition and increase level of harm including increased length of stay, level of intervention required and potential increase in mortality, breach of social distancing measures, which would increase spread of infection and/or potential outbreak. Inability to bring patients into the department from ambulances, detrimental impact to the community in terms of redeployment/response of ambulances, inability to meet privacy and dignity needs of patients, breach of performance measures as set out and monitored by Welsh Government, and pressure on the workforce, i.e. increase in workload due absences, difficulty in recruitment and retention of staff.

To be populated following approval

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. Site escalation policy in place. 2. Infection prevention policy in place. 3. Welsh Government guidelines in place. 4. Standard Operating Procedure (SOP) for the management of patients held in ambulances outside ED. 4. Pathways in place for re-direction of appropriate patients to services such as Urgent Primary Care Centre (UPCC), fracture clinic and mental health liaison from triage. 5. Matrons documentation audit in place to identify areas i.e. welfare checks. 6. Unscheduled care improvement plan group in place to improve patient flow throughout the organisation.	1. Risk is reviewed at Emergency Care meeting and escalated to East Site Risk Management Group. 2. Risk is reported to East site Local Infection Prevention Group (LIPG) and Emergency Department and East Site Patient Safety and Quality Groups (PSQG). 3. Triage waits Key Performance Indicator data reported each month through the site finance meeting.

7. Additional health care support workers shifts generated to increase ability to perform welfare checks throughout the department with the increase volume of patients. 8. Installed shelter at the point of entry to reduce exposure to the elements whilst awaiting screening.	4. Report to Clinical Effectiveness Group. 5. Performance is monitored through harms, incidents, complaints and handovers.

Gaps in Controls/mitigations
Insufficient Capacity/physical environment to mitigate overcrowding.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-14

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	19510	Review and update ED escalation plan.	Mrs Lindsey Bloor, Directorate General Manager	31/05/2022	This will highlight the demands in the department at the time and ensure named individuals have allocated actions to assist in de-escalating of patients in ED to maintain patient safety.	On track
	19516	Review the action plan for Unscheduled care Improvement Group and identify action holders for updates.	Mrs Hazel Davies, Acute Site Director	06/06/2022	This will de-congest ED of the excessive volume of patients who reside in Ed awaiting specialty beds	On track

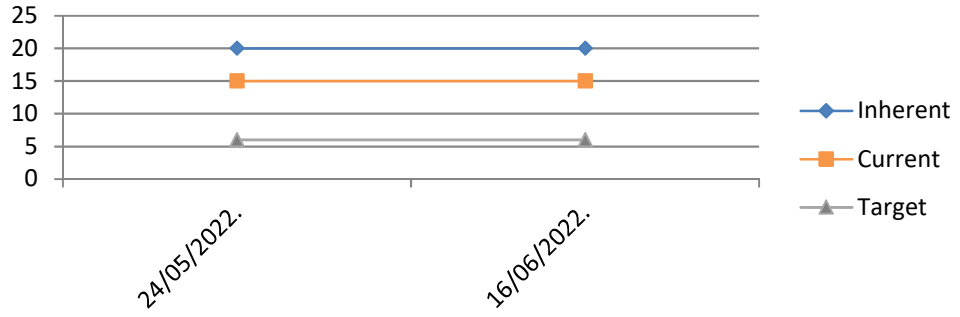
	20605	Increase establishment for additional HCSWs.	Mrs Rachel Bowen, Deputy Head of Nursing EC	22/07/2022	This will increase availability of un-registered workforce to support registered workforce in providing safe and effective care to patients in ED.	On track
	21359	Implement ED risk status.	Mr Nathan Rogers, Lead Manager – Emergency Care	31/05/2022	This will provide awareness to the Site team of the risks being held in Emergency Department and highlight actions to be taken.	On track
	21360	Increasing the footprint of ED to manage overcrowding to protect the minor injury stream (WMH).	Mrs Hazel Davies, Acute Site Director	01/12/2022	It will enable relocation of the minor stream of patients in ED to an alternative area which will reduce overcrowding within the department.	On track
	23001	Ongoing recruitment to approved business case.	Mrs Lindsey Bloor, Directorate General Manager	31/08/2022	This will support staffing in additional areas of ED once available.	On track
	23002	Increase the number of ambulant patient at Ambulatory Emergency Care/ Same Day Emergency Care (SDEC).	Mrs Jackie Evans, AMU Matron	16/09/2022	This will reduce the number of patients in ED waiting room.	On track

CRR22-24	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 04 April 2022
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 16 June 2022
	Risk: Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	**Date of Committee Review:** New Risk
		Target Risk Date: 31 October 2022

There is a risk of senior leadership capacity & capability gaps during the transition to the new Operating Model as people depart the organisation through the VERS process and the challenges recruiting people to new posts (internally and externally)in readiness for the yet to be agreed go-live date.

This has been caused by the delay to the organisational change process resulting in a divergence of parallel actions relating to those individuals leaving the organisation via VERS, the subsequent vacant posts and the recruitment to the new posts. The default position is to use the mechanism of internal backfill. Where a suitable individual cannot be identified then the posts will need to fill by external subject matter experts on an interim basis.

This may lead to a slowdown in the decision making processes as decision and action delivery defaults up to the next level in the responsibility and accountability framework.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. For the small number of posts which will become vacant the default option will be to look internally for people who can step-up on a short-term interim basis. Acting arrangements being agreed with Executives as a mitigation. Where this is not possible we will then look to use to experienced external interims. 2. The management oversight of the transition for those and induction of new teams members is a critical role of the programme of work called: How We Organise Ourselves and the project group called the roles and the people. Arrangements have developed for these leaving us including the	1. Risks are reviewed every 8 weeks by the Risk Management Group (Board and Director level).

Operational transition plan and Leaving Well Handover Guide & Repository. These products along with a suite of induction and network products will support new people and emerging teams with knowledge transfer. 3. The transition of affected departments will be overseen by Executive Directors between April and September 2022. There will be additional management oversight of the How We Organise Ourselves programme, as well as the 'Roles and People' project team.	

Gaps in Controls/mitigations
1. Capacity of Executive Directors to respond to rapid decision making requirements. How We Organise Ourselves now has regular weekly slot on the Executive agenda. 2. The management of the East, Central and West IHC Operational Transition project plans through weekly status meetings and the connectivity to the Programme Leader Group provides a route for rapid escalation of possible gaps. 3. Demand for interim roles across the UK health sector could out-strip supply. 4. An early go-live date could result in vacant new posts where backfill arrangements are not appropriate as those who are acting up into existing posts will have been appointed to their new role and the interim contract period could be too short to attract interested parties.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler)	BAF21-18

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	23233	Inform relevant groups of interim backfill arrangement opportunities - current structure	Gill Harris, Deputy CEO/Executive Director of Integrated Clinical Services	03/06/2022	Action completed 20/06/2022. No gaps in senior leadership roles	Completed

	23234	Equitable backfill selection process	Lesley Hall, Assistant Director – Employment Strategies & Practices	03/06/2022	Action Completed 31/05/2022 No gaps in senior leadership roles	Completed
	23236	Recruitment agencies on standby if required	Mr Steven Gregg-Rowbury, Head of Resourcing	03/06/2022	Action Completed 16/06/2022 No gaps in senior leadership roles	Completed
	23319	Search and selection agencies on standby once the outcome of the preference processes are complete	Mr Steven Gregg-Rowbury, Head of Resourcing	03/06/2022	Action Completed 16/06/2022 No gaps in senior leadership roles	Completed
	23332	Set-up internal selection process for Senior Management posts (format, panel representation)	Lesley Hall, Assistant Director – Employment Strategies & Practices	27/06/2022	No gaps in senior leadership roles.	On track
	23333	Set-up external selection process for Senior Management posts (format, panel representation) (If required)	Lesley Hall, Assistant Director – Employment Strategies & Practices	25/07/2022	No gaps in senior leadership roles.	On track
	23334	Set-up internal selection process for Senior Nursing posts (format, panel representation)	Lesley Hall, Assistant Director – Employment Strategies & Practices	27/06/2022	No gaps in senior leadership roles.	On track
	23335	Set-up internal selection process for Senior Medical posts (format, panel representation)	Lesley Hall, Assistant Director – Employment	18/07/2022	No gaps in senior leadership roles.	

			Strategies & Practices			
	23336	Set-up external selection process for Senior Nursing posts (format, panel representation) (If required)	Lesley Hall, Assistant Director – Employment Strategies & Practices	01/08/2022	No gaps in senior leadership roles.	On track
	23337	Set-up external selection process for Senior Medical posts (format, panel representation) (If required)	Lesley Hall, Assistant Director – Employment Strategies & Practices	22/08/2022	No gaps in senior leadership roles.	On track

Appendix 2 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	20
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-11	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2		
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	20
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	16
CRR21-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR21-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-20	There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents.	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR21-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16
CRR21-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15

Appendix 3 - Risk Key Field Guidance / Definitions of Assurance Levels V2

BAF / Risk Template Item	Please refer to the Risk Management Strategy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Appendix 3 - Risk Key Field Guidance / Definitions of Assurance Levels V2

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Report title:	Update on the SORD to meet the new Operating Model		
Report to:	Audit Committee		
Date of Meeting:	Thursday, 30 June 2022	Agenda Item number:	
Executive Summary:	The Health Board currently operates 16 different operational Schemes of Reservation and Delegation (SORD). In line with the move to the new Operating Model, there is the need for standardisation, consistency and clarity in relation to the delegation of Matters from the Board through the Executive Team down to the Operational Divisions and Services. This clarity and standardisation in relation to Delegated Matters will be set and delivered through one single Health Board wide SORD, which covers all Operational Divisions and Support Functions.		
Recommendations:	The Audit Committee is asked to: 1. Note that all narrative in red is where additions or amendments have been made from the SORD approved by the Audit Committee in March 2022. 2. Note the addition and clarity of the flow of Delegated Matters through the Board & Executive to the Operational front-line (as per the 3 columns within Schedule 1 of the SORD) 3. Within Table B2, recognise that this will be populated as and when the next tier of structures are agreed, either in the IHC, other Division or Support Function, as such this SORD will continue to be updated during the next 6 to 12 months. 4. Note that implementation locally (in the first instance) will be through the Chief Finance Officers (CFO's) working with their IHC / Divisional Management Teams; as this is largely about Financial Limits & Controls it is logical for it to be via the CFO's. This will be implemented as part of the overall Governance & Assurance Framework. 5. **Approve this version and approach, and the continued development of the next level of detail (as posts are agreed within the structures) ready for implementation alongside the Operating Model go-live.**		
Executive Lead:	Molly Marcu, Board Secretary		
Report Author:	Nigel McCann, CFO Central Area		
Purpose of report:	For Noting ☐	For Decision ☒	For Assurance ☒

Assurance level:	Significant ☐	Acceptable ☒	Partial ☐	No Assurance ☐
	High level of confidence/evidence in delivery of existing mechanisms / objectives	General confidence/evidence in delivery of existing mechanisms / objectives	Some confidence/evidence in delivery of existing mechanisms / objectives	No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Not applicable	
Link to Strategic Objective(s):	ALL
Regulatory and legal implications	The SORD is a key component of Financial and Operational Governance within the Standing Orders (SO's) and Standing Financial Instructions (SFI's).
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below**	**N**
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Until such a time as the new Divisional level management structures are agreed, existing operational SORD authority and approval limits will remain extant.
Financial implications as a result of implementing the recommendations	Budget and Financial Management training and controls will be strengthened as part of the process of moving to the new Operating Model.
Workforce implications as a result of implementing the recommendations	Not applicable
Feedback, response, and follow up summary following consultation	This has been through the Executive Team and the Operating Model Governance and Project Team / SRO meetings
Links to BAF risks: (or links to the Corporate Risk Register)	All
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:

- Following approval from the Audit Committee, the SORD will continue to be developed through the Board Secretary and Executive Team within the Operating Model timescales.
- The Audit Committee will received regular updates on the development and implementation progress, specifically noting any and all changes and amendments made between Committee meetings.

List of Appendices:

- SORD Version 6

SECTION 2: SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS,

OTHER DIRECTORS AND OPERATIONAL BUDGET MANAGERS

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

Delegated Matter	**Table Reference No.**
STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS	1
MEETINGS	2
FINANCIAL PLANNING/BUDGETARY RESPONSIBILITY	3
BANK/PGO ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS)	4
UNALLOCATED	5
NON PAY EXPENDITURE	6
STORES AND RECEIPT OF GOODS	7
CAPITAL INVESTMENT MANAGEMENT	8
QUOTATIONS, TENDERING & CONTRACT PROCEDURES	9
FIXED ASSETS	10
PERSONNEL & PAY	11
ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT)	12
CHARITABLE FUNDS HELD ON TRUST	13
PRIMARY CARE PATIENT SERVICES/HEALTHCARE AGREEMENTS	14
INCOME SYSTEMS, FEES & CHARGES	15
DISPOSAL AND CONDEMNATIONS	16
LOSSES, WRITE-OFFS & COMPENSATION AND EX-GRATIA PAYMENTS	17
REPORTING INCIDENTS TO THE POLICE	18
FINANCIAL PROCEDURES	19
AUDIT ARRANGEMENTS	20
LEGAL PROCEEDINGS	21
INSURANCE POLICIES AND RISK MANAGEMENT	22
CLINICAL AUDIT	23
PATIENTS' PROPERTY	24
PATIENTS' & RELATIVES' COMPLAINTS	25
SEAL	26
GIFTS & HOSPITALITY	27
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INFORMATICS AND THE DATA PROTECTION ACT	29
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AUTHORISATION OF NEW DRUGS	31
AUTHORISATION OF RESEARCH PROJECTS	32
AUTHORISATION OF CLINICAL TRIALS	33
INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS	34

Delegated Matter	Table Reference No.
REVIEW OF FIRE PRECAUTIONS	35
HEALTH & SAFETY	36
MEDICINES INSPECTORATE REGULATIONS	37
ENVIRONMENTAL REGULATIONS	38
LEGAL & RISK PAYMENTS	39
INVESTIGATION OF FRAUD/CORRUPTION OR FINANCIAL IRREGULARITIES	40
COMMERCIAL SPONSORSHIP	41
COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS	42
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COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO	44
EMERGENCY PLANNING	45
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STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION	47
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WELSH LANGUAGE STANDARD REPORTING	54
CONTROLLED DRUGS ACCOUNTABLE OFFICER	55
UPHOLDING PROFESSIONAL STANDARDS IN WALES (UPSW)	56

Schedule 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS

Table A – Scheme of Delegation to Officers

Board Member Responsible: in line with the Standing Orders, delegated approval to the relevant Board Member, Board Committee or Executive Director.

Specific Delegation Where Applicable : The intention within the Operating Model is to delegate to the Operational Divisions wherever possible, however some Matters are either delegated through a Director, Associate or Assistant then to the Operational Division, or they are not delegate beyond this secondary level. This column sets out the delegation flow where relevant.

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

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
1. Standing Orders / Standing Financial Instructions			
a) Final authority in interpretation of Standing Orders	Chair	Not Delegated	Not Delegated
b) Notifying Directors, employees and agents of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Executive Director of Finance/Board Secretary	Direct to Operational Services →	Service Director** (**Generic Title used for the 'Accountable Lead' across IHC, Pan BCU, Regional Directors and Support Functions)
c) Responsibility for the security of the LHB's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Executive Director of Finance	Direct to Operational Services →	Service Director
d) Ensuring Standing Orders are compatible with Welsh Government requirements re building and engineering contracts	Chief Executive	Executive Director of Finance	Not Delegated
2. Meetings			
a) Calling meetings of the LHB	Chair	Board Secretary	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Chair all LHB Board meetings and associated responsibilities	Chair or Vice Chair in Chair's absence	Not Delegated	Not Delegated
3. Financial Planning/Budgetary Responsibility			All Matters locally supported by CFO / FD
a) Setting: Submit Three Year Plan and Annual Operating Plan to the LHB Board	Chief Executive	Executive Director of Transformation and Planning	Not Delegated
Submit budgets to the LHB Board	Chief Executive	Executive Director of Finance	Not Delegated
Submit to Board financial estimates and forecasts	Chief Executive	Executive Director of Finance	Not Delegated
b) Implementing financial policies, plans and procedures, providing advice and co-ordinating any corrective action necessary	Executive Director of Finance	Director: Operational Finance	Service Director
c) Issuing Budgets	Executive Director of Finance	Finance Director: Operational Finance	Service Director
d) Monitoring: Monitor performance against budget	Executive Director of Finance	Executive and Associate Directors	Service Director
Submit monitoring returns	Chief Executive	Executive Director of Finance	Not Delegated
Effective budgetary control and a balanced budget	Executive Director of Finance	Executive and Associate Directors	Service Director
Preparation of annual accounts and returns	Executive Director of Finance	Executive Director of Finance	Not Delegated
Identifying and implementing cost improvements and income generation initiatives	Executive Director of Finance	Executive and Associate Directors	Service Director
e) Authorisation of Virement It is not possible for any officer other than the Executive Director of Finance to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders (Service Directors) requires the agreement of both parties.	Executive Director of Finance	Please refer to Table B – Delegated Limits	Service Director
f) Maintaining an effective system of internal financial control	Chief Executive	Executive Director of Finance	Service Director
g) Delivery of financial training to budget holders (Directors)	Executive Director of Finance	Finance Director: Operational Finance	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
4. Bank/PGO Accounts (Excluding Charitable Fund Accounts)			
a) Operation: Managing banking arrangements and operation of bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Opening bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Authorisation of transfers between LHB bank accounts	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated
Authorisation of: -PGO/GBS Schedules -BACS Schedules -Automated cheque schedules -Manual cheques	Executive Director of Finance	Finance Director: Operational Finance	Not Delegated to Service Directors. NOTING that Senior Finance Staff (CFO / FD) authorise contract / SLA / RIF payments
5. Non Pay Expenditure			
For details of Delegated Limits refer to Table B			
a) Completion of an Operational Scheme of Delegation and Authorisation by each Budget Holder ensuring maintenance of a list of officers authorised to place requisitions/orders (including emergency verbal orders) and record receipts within the E-Financials Business Suite.	Executive Director of Finance	Executive and Associate Directors	Service Director
b) Obtain the best value for money when requisitioning goods/services	Executive Director of Finance	Executive and Associate Directors	Service Director
c) Ensuring expenditure is within budget	Chief Executive	Executive and Associate Directors	Service Director
d) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive	Executive Director of Finance	Service Director
e) Orders exceeding 12 month period	Executive Director of Finance	Finance Director: Operational Finance	Service Director
f) Prompt payment of accounts	Executive Director of Finance	Executive Director of Finance	Not Delegated
g) Financial Limits	Executive Director of Finance	Direct to Operational Services → Refer to Table B for Delegated Limits	Service Director Per Table B
h) Maintenance of sufficient records to explain the LHB's transactions and report on the LHB's financial position	Executive Director of Finance	Finance Director: Operational Finance	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
i) Provision of electronic signature / approval within the E-Financials Business Suite in accordance with each Budget Holder's Operational Scheme of Delegation and Authorisation	Executive Director of Finance	Finance Director: Operational Finance	Service Director
6. Stores and Receipt of Goods			
a) Responsibility for the systems of financial control over all stores including receipt of goods and returns	Executive Director of Finance	Direct to Operational Services →	Service Director
b) Responsibility for the control of stores and of goods, issues and returns: (excluding pharmaceutical stock: see below)	Executive Director of Finance	Direct to Operational Services →	Service Director
Pharmaceutical Stores	Executive Medical Director	Chief Pharmacist	Service Director Via Head of Medicines Management
c) Stocktaking arrangements	Executive Director of Finance	Direct to Operational Services →	Service Director
7. Capital Investment Management For details of Delegated Limits for Delegated Matter 8d, please refer to Table B – Leases. In accordance with Welsh Government guidance:			
a) Programme:			
Preparation of Capital Investment Programme	Chief Executive	Executive Director of Finance	Service Director
Completion and signing off of a business case for approval	Executive Director of Finance	Director of Finance; Operations	Service Director
Appointment of Project Directors	Chief Executive	Executive Director of Finance with support from relevant Directors	Not Delegated
Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Executive Director of Finance	Executive Director of Finance with support from relevant Directors.	Service Director
Issuing of guidance on management of capital schemes	Executive Director of Finance	Executive Director of Finance with support from relevant Directors.	Not Delegated
b) Contracting – Selection of 3rd party developers, architects, quantity surveyors, consultant engineers and other professional advisors within EC regulations and LHB tender procedures	Chief Executive	Executive Director of Finance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
c) Private Finance – Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector	Chief Executive	Executive Director of Finance	Not Delegated
d) Leases – Granting and termination of leases	Chief Executive	Executive Director of Finance	Refer to Table B
e) Financial control and audit- Arrangements are in place to review building and engineering contracts and property transactions comply with Welsh Government guidance.	Chief Executive	Executive Director of Finance	Not Delegated
8. Quotations, Tendering & Contract Procedures For details of Delegated Limits, please refer to Table B – Quotations/Tenders.			All Matters locally supported by CFO / FD
a) Services:			
Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Direct to Operational Services →	Service Director
Nominate officers to oversee and manage the contract on behalf of the LHB	Chief Executive	Direct to Operational Services →	Service Director
b) Quotations – Total value of the contract over its entire period:			
Seeking quotations up to £5,000 in value	Executive Director of Finance (per SFI 11.7.1)	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Executive Director of Finance (per SFI 11.1.2)	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
c) Competitive Tenders – Total value of the contract over its entire period:			
Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EC Directives as appropriate)	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EC Directives as appropriate)	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
Receipt and custody of tenders prior to opening	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
Opening Tenders and Quotations	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director
Decide if late tenders should be considered	Executive Director of Finance	Direct to Operational Services → Refer to Table B for delegated limits	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Waiving the requirement to request quotes or tenders – subject to SFI Schedule 1 Para. 4.2 & 4.3 – Formally reported to the Audit Committee	Executive Director of Finance	Finance Director: Operational Finance (escalation to the Executive Director of Finance or Chief Executive if necessary) The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from.one other Executive Directors	Service Director All Single Tender Waivers (STW's) must be approved by NWSSP and by the Operational Finance Director **before** any commitment is made.
9. Fixed Assets			
a) Maintenance of asset register	Executive Director of Finance	Finance Director (Operational Finance)	Service Director
b) Calculate and pay capital charges in accordance with Welsh Government requirements	Executive Director of Finance	Finance Director (Operational Finance)	Not Delegated
c) Responsibility for fixed assets – Land & Buildings	Executive Director of Finance	Director of Estates	Not Delegated
d) Responsibility for all other fixed assets (Plant, Machinery, Transport, IT assets including software, Furniture & Fittings)	Executive Director of Finance	Director of Estates and Director of Digital, Deputy CEO with support from relevant Directors.	Service Director
e) Responsibility for security of LHB assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with LHB procedures	Chief Executive	Executive Director of Finance, with support from relevant Directors.	Service Director
10. Personnel & Pay			All Matters locally supported by CFO / FD / People
a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks.	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
b) Approve the commencement of employment prior to all pre-employment checks being completed.	Executive Director of Workforce & OD	Associate Director People Services	Service Director
c) Authority to fill funded post on the establishment with permanent staff.	Executive Director of Workforce & OD	Deputy Director Workforce & OD Associate Director of People Services (IHC/PAN	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
		BCU/Support Services)	
d) The granting of additional increments to staff within budget in accordance with Terms & Conditions of Service	Executive Director of Workforce & OD	Executive Directors with advice from Associate Director of people Services	Service Director
e) All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with LHB Procedure	Executive Director of Workforce & OD	Executive Directors with advice from Associate Director of people Services	Service Director
f) Authority to agree acting up salaries for staff other than Executive Directors, within budget (Approval of acting up salaries for interim Executive Directors to be retained by Remuneration & Terms of Service Committee)	Chief Executive to agree acting up arrangements of Band 9 and above (Excluding Executive Directors)	Executive Directors lead for acting up salaries up to Band 9 or equivalent.	Service Director Up to Band 9 or equivalent only.
g) Establishments:			
Locum/additional staff to the agreed establishment **with** specifically allocated finance	Executive Director of Workforce & OD / Executive Director of Finance	Direct to Operational Services →	Service Director
Locum/additional staff to the agreed establishment **without** specifically allocated finance.	Chief Executive	Executive Director of Finance and Executive Director of Workforce & OD	Service Director (via ECR & Budget Virement)
Variation to the funded establishment	Executive Director of Workforce & OD and Executive Director of Finance	Direct to Operational Services → with Budget Virement approval in line with Executive Director of Finance Policy	Service Director (Via ECR & Budget Virement)
h) Pay			
Authority to complete standing data forms effecting pay, new starters, changes and leavers	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Authority to complete and authorise timesheets and payroll returns	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Authority to authorise overtime	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Authority to authorise travel & subsistence expenses	Executive Director of	Direct to Operational Services →	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
	Workforce & OD		
Maintenance of a list of managers authorised to sign payroll and travel expense documentation. (and via e-expense systems)	Executive Director of Workforce & OD	Deputy Director of Workforce & OD	Service Director
i) Leave			
Approval of annual leave in accordance with LHB policy	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Compassionate leave	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Special leave arrangements (to be applied in accordance with All Wales Policy)	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Leave without pay	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Medical Staff Leave of Absence – paid and unpaid	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Consultants Special Leave	Executive Medical Director	Direct to Operational Services →	Service Director
Time off in lieu	Executive Director of Workforce and OD	Direct to Operational Services →	Service Director
Maternity / Paternity Leave – paid and unpaid	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
j) Annualised hours/flexible working hours system- maintenance of adequate records	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
k) Sick Leave			
Extension of sick leave on half pay up to three months	Executive Director of Workforce & OD	Direct to Operational Services → in conjunction with Associate Director of People Services	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Return to work part-time on full pay to assist recovery	Executive Director of Workforce & OD	Direct to Operational Services → in conjunction with Associate Director of People Services	Service Director
Extension of sick leave on full pay	Executive Director of Workforce & OD	Direct to Operational Services → in conjunction with Associate Director of People Services	Service Director
l) Study Leave			
Study leave outside the UK (non-medical staff excluding clinical staff)	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
Medical staff study leave (UK)	Executive Medical Director/ Executive Director of Workforce & OD/ Executive Director of Integrated Clinical Delivery	Direct to Operational Services →	Service Director
Consultant Medical Staff Leave (UK)	Executive Medical Director	Direct to Operational Services →	Service Director
All Medical and non-Medical Clinical Staff study leave outside the UK	Executive Medical Director/ Executive Director of Nursing & Midwifery/ Executive Director of Therapies & Health Science/ Executive Director of Integrated Clinical Delivery	Direct to Operational Services →	Service Director
All other study leave (UK)	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
m) Removal Expenses			
Authorisation of payment of removal expenses incurred by officers taking up new	Executive Director of	Direct to Operational Services →	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
appointments (providing consideration was promised at interview)	Workforce & OD	In accordance with BCUHB policy / approval from the Executive Director of Workforce & OD	
n) Respect & Resolution Procedure	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
o) Professional Misconduct/Competence- Medical and Dental Staff	Executive Medical Director/ Executive Director of Workforce & OD	Deputy Responsible Officer / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
p) Suspension of Doctors employed directly by the LHB	Executive Medical Director	Deputy RO / Deputy Medical Director / Deputy Director of Workforce & OD	Not Delegated
q) Removal of Practitioner from the Performers List	Chief Executive	Executive Medical Director supported by Executive Director of Workforce & OD and Executive Director of Integrated Clinical Delivery	Not Delegated to Operational Divisions, cover for Executive Medical Director provided through the Deputy RO or Deputy Medical Director
r) Requests for new posts to be authorised as car users	Executive Director of Finance	Direct to Operational Services →	Service Director
s) Renewal of Fixed Term Contract	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
t) Voluntary Early Release Scheme	Remuneration and Terms of Service Committee (supported by Executive Director of Workforce & OD)	Executive Director of Workforce & OD, with Executive Director of Finance for sign off of financial viability	Not Delegated
u) Settlement on termination of employment	Executive Director of Workforce & OD	Executive Director of Workforce & OD with approval from Welsh Government where the payment is Ex-gratia and exceeds the delegated limit of £50,000	Not Delegated. Service Directors to operate within Policy as set through the Executive Director of Workforce & OD

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
v) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department	Executive Director of Workforce & OD	Associate Director of People Services	Service Director for local implementation : Ultimate Approval is via NHS Pensions Agency
w) Disciplinary Procedure (excluding Executive Directors)	Executive Director of Workforce & OD	Executive Directors	Service Director
11. Engagement of Staff Not On the Establishment			
For details of Delegated Limits, please refer to Table B			All Matters locally supported by CFO / FD / People
a) Non clinical Consultancy Staff	Executive Director of Finance	Direct to Operational Services →	Service Director
b) Medical Locum staff	Executive Medical Director	Direct to Operational Services →	Service Director
c) Booking of Agency Nursing Staff	Executive Director of Nursing & Midwifery	Direct to Operational Services →	Service Director
d) Booking of Bank Staff:			
Nursing	Executive Director of Nursing & Midwifery	Direct to Operational Services →	Service Director
Other	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director
12. Charitable Funds Held on Trust			
For details of Delegated Limits, Please refer to Table B			All Matters locally supported by CFO / FD
a) Management: Funds held on Trust are managed appropriately	Executive Director of Finance	Direct to Operational Services →	Service Director
b) Maintenance of authorised signatory list of Authorised Fund Holders	Executive Director of Finance	Executive Director of Finance	Service Director
c) Expenditure	Executive Director of Finance	Direct to Operational Services → Refer to Table B – Delegated limits	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance	Director of Communications and Partnerships	Fundraising manager,	Service Director Via Awyr Las
e) Operation of Bank Accounts:			
Managing banking arrangements and operation of bank accounts	Executive Director of Finance in conjunction with Corporate Trustees	Executive Director of Finance	Not Delegated
Opening bank accounts	Corporate Trustee	Executive Director of Finance	Not Delegated
f) Investments – Policy and Arrangements	Executive Director of Finance in conjunction with Corporate Trustees	Executive Director of Finance	Not Delegated
g) Authority to accept the discharge of a donor's estate	Executive Director of Finance	Executive Director of Finance	Not Delegated Via Awyr Las
13. Primary Care Patient Services/ Healthcare Agreements For details of Delegated Limits, please refer to Table B – Healthcare Agreements			**SEE TABLE B FOR SPECIFIC SENIOR POSTS & £ LIMITS**
a) Contract negotiation and provision of service agreements	Executive Director of Finance / Executive Director of Integrated Clinical Delivery	Executive Director of Finance / Executive Director of Integrated Clinical Delivery	System Oversight
b) Reporting actual and forecast contract income	Executive Director of Finance	Executive Director of Finance	System Oversight (supported by Finance)
c) Pricing of all contracts and SLAs	Executive Director of Finance	Executive Director of Finance with relevant Director	Not Delegated
d) Signing agreements	Chief Executive	Chief Executive or Executive Director of Finance in Chief Executive's absence/Executive Director of Integrated Clinical Delivery for all primary care related agreements	Service Director (see Table B for specific limits and arrangements)

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
14. Income Systems, Fees and Charges			All Matters locally supported by CFO / FD
a) Private Patients, Overseas Visitors, Income Generation and other patient related services	Executive Director of Finance	Executive Director of Finance	Service Director
b) Pricing of NHS agreements	Executive Director of Finance	Assistant Directors of Finance	Not Delegated
c) Informing the Director of Finance of monies due to the LHB	Executive Director of Finance	Direct to Operational Services →	Service Director
d) Recovery of debt	Executive Director of Finance	Finance Director: Operational Finance.	Not Delegated
e) Security of cash and other negotiable instruments	Executive Director of Finance	Finance Director: Operational Finance.	Service Director
f) Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Executive Director of Finance	Finance Director: Operational Finance	Service Director
g) Non patient care income	Executive Director of Finance	Finance Director: Operational Finance.	Service Director
15. Disposal and Condemnations Disposal of all property and land requires formal approval by the Minister for Health and Social Services			
a) Issuing procedure for the disposal of assets obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Executive Director of Finance	Executive Director of Finance	Not Delegated
b) Notification to Director of Finance prior to disposal	Executive Director of Finance	Direct to Operational Services →	Service Director
16. Losses, Write-offs & Compensation			
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing Counter Fraud Operational Services of frauds.	Executive Director of Finance	Finance Director: Operational Finance.	Service Director For Implementation and compliance with BCU Procedure
b) Losses of cash due to theft, fraud, overpayment of salaries, fees, allowances & other causes up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
c) Fruitless payments (including abandoned Capital Schemes) up to £250,000	Chief Executive	Executive Director of Finance	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
d) Bad debts and claims abandoned: Private patients; overseas visitors & other cases up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
e) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive	Executive Director of Finance	Not Delegated
f) For personal and public liability claims, under the Legal & Risk scheme, authorisation from Legal & Risk is required before admissions may be made and monetary compensation offered. (Ex-gratia settlements offered by the LHB are by definition not payments based upon legal liability and are, therefore, not reimbursable under the WRP scheme)	Chief Executive	Executive Director of Nursing & Midwifery supported by the relevant Director after seeking appropriate legal advice, up to a max £150,000	Service Director For Implementation and compliance with BCU Procedure
g) Compensation payments made under legal obligation:	Chief Executive	Chief Executive, Executive Director of Finance or Executive Director of Nursing & Midwifery	Not Delegated
h) Extra contractual payments to contractors – Up to £50,000 as specified within the Losses and Special Payments Manual of Guidance	Chief Executive	Executive Director of Finance with reporting to the Audit Committee	Not Delegated
16.1 Ex-Gratia Payments: (per Manual for Accounts Chapter 6)			
a) Patients and staff for loss of personal effects up to £50,000 Above £50k to Welsh Government	Chief Executive	Executive Director of Finance- Refer to Finance Policy on Losses and Special Payments	Service Directors to Implement: financial approval remains within Finance Department per Policy
b) For clinical negligence up to £250,000 (negotiated settlements)*. Report to Board > £50,000 (Table B)	Chief Executive	Executive Director of Finance/Executive Director of Nursing & Midwifery	Not Delegated
c) For clinical negligence over £250,000 and up to £1,000,000* (negotiated settlements). Report to Board> £50,000 (see Table B)	Chair Board	Chief Executive/ Executive Director of Finance/Executive Director of Nursing & Midwifery	Not Delegated
d) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £250,000 (including plaintiff's costs) Report to Board > £50,000	Board	Chief Executive/ Executive Director of Finance/Executive Director of Workforce & OD/ Executive Director of Nursing & Midwifery	Not Delegated
e) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 (>£1m to Welsh Government)	Board	Chief Executive/Executive Director of Finance/Executive	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
Report to Board > £50,000*		Director of Nursing & Midwifery	
f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000 Above £50k to Welsh Government	Chief Executive	Executive Director of Finance/Executive Director of Nursing & Midwifery	Not Delegated
* For all clinical negligence and personal injury cases(including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more **– All structured settlements require approval from the Welsh Government**	Board	Chief Executive Executive Director of Finance/Executive Director of Nursing & Midwifery	Not Delegated
17. Procedure to follow after reporting of incidents to the Police			
a) Where a criminal offence is suspected	Executive Director of Finance	Direct to Operational Services →	Service Director For Implementation and compliance
b) Criminal offence of a sexual or violent nature	Executive Director of Workforce & OD	Direct to Operational Services →	Service Director For implementation and compliance
c) Arson or theft	Executive Director of Finance	Direct to Operational Services →	Service Director for implementation and compliance
d) Other	Chief Executive	Direct to Operational Services → dependent upon the nature of the suspected offence	Service Director for implementation nd compliance
18. Financial Procedures			
a) Maintenance & Update of LHB Financial Procedures	Executive Director of Finance	Finance Director : Operational Finance	Not Delegated
19. Audit Arrangements			
a) Review, appraise and support in accordance with Internal Audit standards for NHS Wales and best practice	Chair of the Audit Committee	Board Secretary/Head of Internal Audit	Not Delegated
b) Provide an independent and objective view on internal control and probity	Board Secretary	Head of Internal Audit/ Audit Wales	Not Delegated
c) Ensure Cost-effective external audit	Chair of Audit Committee	Executive Director of Finance	Not Delegated
d) Ensure an adequate internal audit service	Chief Executive	Board Secretary	Not Delegated
e) Implement recommendations	Board Secretary	Direct to Operational Services →	Service Director
20. Legal Proceedings			

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
a) Engagement of LHB's Solicitors	Chief Executive	Board Secretary for all Board related matters/Executive Director of Workforce & OD for all employment related matters/Executive Director of Finance for all estate related matters/Executive Director of Integrated Clinical Delivery for all Primary Care related matters. Associate Director of Quality for claims, inquest, MHA and COP matters.	Service Director (Associate Director People Services for employment matters). Out of Hours approval via Gold On-Call.
b) Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive. Associate Director of Quality for claims, inquest, MHA and COP matters.	Not Delegated
c) Sign on behalf of the LHB any agreement or document not requested to be executed as a deed	Chief Executive	Any Executive Director of the Board or an officer formally nominated by the Chief Executive	Not Delegated
21. Insurance Policies and Risk Management	Chief Executive	Executive Director of Finance and Executive Medical Director	Not Delegated (Service Director For **Implementation)**
22. Clinical Audit	Chief Executive	Executive Medical Director	Not Delegated
23. Patients' Property (in conjunction with financial advice)			
For details of Delegated Limits, please refer to Table B – Petty Cash/Patients Monies			
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Executive Director of Nursing & Midwifery	Direct to Operational Services →	Service Director
b) Prepare detailed written instructions for the administration of patients' property	Executive Director of Nursing & Midwifery	Direct to Operational Services →	Service Director
c) Informing staff of their duties in respect of patients' property	Executive Director of	Direct to Operational Services →	Service Director

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
	Nursing & Midwifery		
d) Issuing property valued >£5,000 only on production of a probate letter of administration	Executive Director of Finance	Director: Operational Finance.	Not Delegated
24. Putting Things Right Regulations (in line with WRP Policy & Guidance)			
a) Overall responsibility for ensuring that all concerns (as defined in PTR Regulations) are dealt with effectively	Chief Executive	Executive Director of Nursing & Midwifery. Associate Director of Quality (PTR Deputy Responsible Officer and Senior Investigations Officer)	Service Director For Implementation
b) Responsibility for ensuring complaints are investigated thoroughly, and learning is embedded.	Chief Executive	Executive Director of Nursing & Midwifery. Associate Director of Quality (PTR Deputy Responsible Officer and Senior Investigations Officer)	Service Director For implementation
c) Medical – Legal Complaints Co-ordination of their management	Chief Executive	Executive Director of Nursing & Midwifery. Associate Director of Quality (PTR Deputy Responsible Officer and Senior Investigations Officer)	Service Director For implementation
25. Seal			
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Board Secretary	Not Delegated
b) Attestation of seal in accordance with Standing Orders	Chief Executive/ Chair	Board Secretary	Not Delegated
26. Gifts and Hospitality			
a) Keeping of gifts and hospitality register	Chief Executive	Board Secretary	Service Director for implementation and compliance
27. Declaration of Interests			
a) Maintaining a register of interests	Chief Executive	Board Secretary	Service Director for implementation and compliance
28. Informatics and the Data Protection Act			
a) Review of LHB's compliance with the Data Protection Act	Chief Executive	Director of Digital	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
b) Responsibility for Informatics policy and strategy	Executive Medical Director	Director of Digital	Not Delegated
c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems	Executive Medical Director	Director of Digital	Not Delegated
29. Records			
a) Review LHB's compliance with the Retention of Records Act and guidance	Chief Executive	Director of Digital / Executive Medical Director	Not Delegated
b) Approval for the destruction of records	Chief Executive	Director of Digital / Executive Medical Director	Service Director
c) Ensuring the form and adequacy of the financial records of all departments	Executive Director of Finance	Director: Operational Finance	Service Director
30. Authorisation of New Drugs	Chief Executive	Executive Medical Director on the advice of the appropriate professional bodies	Not Delegated
31. Authorisation of Research Projects	Executive Medical Director	Director of Research & Development	Service Director
32. Authorisation of Clinical Trials	Chief Executive	Medical Director	Service Director
33. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice	Chief Executive	Executive Director of Public Health	Not Delegated
34. Review of Fire Precautions	Chief Executive	Executive Director of Finance	Not Delegated
35. Health & Safety			
Review of all statutory compliance legislation and Health and Safety requirements.	Chief Executive	Executive Director of Workforce & OD	Not Delegated
36. Medicines Inspectorate Regulations			
Review Regulations Compliance	Chief Executive	Executive Medical Director supported by Chief Pharmacist	Service Director via Head of Medicines Management
37. Environmental Regulations			
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Executive Director of Finance	Director of Estates	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
38. Legal & Risk Payments	Chief Executive	Executive Director of Nursing & Midwifery/Executive Director of Finance	Not Delegated **See Table B**
39. Investigation of Fraud/Corruption or Financial Irregularities	Executive Director of Finance	Lead Local Counter Fraud Specialist	Not Delegated
40. Commercial Sponsorship			
Agreement to proposal in accordance with BCU HB procedures	Chief Executive	Executive Director of Finance	Not Delegated
41. Cost/Notional Rent/Third Party Developer/Improvement Grants			All Matters locally supported by CFO / FD
Approval of all schedules of payments	Chief Executive	Executive Director of Integrated Clinical Delivery	Service Director
Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU HB Primary Care Estates Strategy	Chief Executive	Executive Director of Integrated Clinical Delivery	Not Delegated
42. Freedom of Information	Chief Executive	Director of Digital	Service Director
43. Compliance Lead Roles:			
a) Caldicott Guardian	Executive Medical Director	Deputy Medical Director	Not Delegated
b) Data Protection Officer	Chief Executive	Director of Digital	Not Delegated
c) Senior Information Risk Owner	Chief Executive	Executive Director of Finance	Not Delegated
44. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)	Chief Executive	Executive Director of Integrated Clinical Delivery	Not Delegated
45. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities	Chief Executive	Executive Director of Finance	Service Director (CFO / FD Supported) **See also Table B**
46. Statutory compliance with respective Legislation	Chief Executive	Board Secretary	Service Director for implementation
47. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument	Chief Executive	Executive Directors	Not Delegated

DELEGATED MATTER	BOARD MEMBER RESPONSIBLE	SPECIFIC DELEGATION WHERE APPLICABLE	OPERATIONAL RESPONSIBILITY
2005: 3039) Appointment of all Medical and Dental Consultant posts. Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.			
48. All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)	Chief Executive	WHSSC IPFR Panel £300,000 to £1,000,000; Chief Executive up to £299,999; Chair and Vice Chair of Health Board IPFR Panel together sign up to £125,000	Not Delegated
*** The IPFR Panel cannot make policy decisions for the health board. Any policy proposals arising from their considerations and decisions must be reported to the Health Board Quality, Safety & Experience Committee**			
49. Carbon Reduction Commitment Order (Phase 2) Agency Registration	Chief Executive	Executive Director of Finance	Not Delegated
50. Human Tissue Act 20014	Chief Executive	Executive Medical Director	Service Director for implementation
51. Ionising Radiation (Medical Exposure) Regulations 2017	Chief Executive	Executive Director of Therapies & Health Sciences / Executive Medical Director	Service Director for implementation
52. Nurse Staffing Levels Act (Wales) 2016	Chief Executive	Executive Director of Nursing & Midwifery	Service Director for implementation
53. Welsh Language Standard Reporting	Chief Executive	Executive Director of Public Health	Service Director for implementation
54. Controlled Drugs Accountable Officer	Chief Executive	Chief Pharmacist	Not Delegated
55. Upholding Professional Standards in Wales (UPSW):			
Responsible Officer	Executive Medical Director (SRO)	Deputy Medical Director (Deputy Responsible Officer)	Service Director for implementation
Appointing a Designated Board Member	Health Board Chair	Remuneration & Terms of Service Committee	Not Delegated

Table B – Scheme of Financial Delegation

Financial Limits are subject to funding available within relevant budget(s) and are inclusive of VAT irrespective of recovery arrangements.

All purchases must ensure compliance with Standing Financial Instruction Schedule 1 - Procurement of Works, Goods and Services with regard to the required quotation or Tendering exercise.

	Budget changes	General expenditure	Healthcare agreements	Revenue and Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.														
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishment)	Agency and Waiting List Initiatives (all values)
WG (In advance of contract planning)	No requirement	£1m plus	£1m plus (Private sector)	£1m plus	£1m plus	£1m plus	No requirement	£1m plus	See WRP and Manual of Guidance for losses and SFIs, as special rules apply for certain losses and ex gratia payments.	No requirement	No requirement	No requirement	No requirement	No requirement	No requirement
Board following Chief Executive approval	£1m plus	£1m plus	Over £10m approved in advance, below £10m retrospectively reported. Over £1m for Private sector.	£1m plus	£1m plus	£1m plus	£0.5m plus or any which need signing under seal (Reservation of Power, Number 33)	£0.5m plus		£1m plus	No requirement	No requirement	No requirement	No requirement	No requirement
Performance, Finance and Information Governance Committee				Up to £1m	Up to £1m	Up to £1m									
Audit Committee													Retrospective reporting		
Charitable Funds Committee (all Executives can authorise use of charitable funds up to £5k)											Over £5k (Up to £25k scrutinised by CF Advisory Group)	Over £5k (Up to £25k scrutinised by CF Advisory group)			
CEO	£0.5m to £1m	£0.5m to £1m	New or contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m (>£1m to Board)	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement
Deputy CEO	£0.5m to £1m	£0.5m to £1m	New or contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m (>£1m to Board)	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement

	Budget changes	General expenditure	Healthcare agreements	Revenue and Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.														
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishment)	Agency and Waiting List Initiatives (all values)
Any 2 of CEO, Executive Director of Integrated Clinical Delivery and DoF (must include DoF)		Up to £0.5m	New or contract variation to £5.0m (to £1m for Private sector).					Up to £250k		Up to £0.5m			As escalated by DoF		
Executive Director of Finance	£0.5m to £1m	£0.5m to £1m	New / contract variation to £10.0m.	£0.5m to £1m	£0.5m to £1m	£0.5m to £1m	£250k to £0.5m	£250k to £0.5m	£0.5m to £1.0m	£0.5m to £1.0m	Up to £5k	Up to £5k	As escalated by DoF	Can approve new posts across LHB	No requirement
Executive Directors, (not noted below)		Up to £300k						Up to £100k					All Single Tender Waivers are created within the Services and approved by the relevant Service Director, however all STW's must be approved by FD: OF and Executive Director of Finance or Chief Executive if escalated by FD: OF	Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director Transformation & Improvement	Within own delegated budget	Up to £300k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Medical Director	Within own delegated budget	Up to £300k				Up to £0.5m		Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Public Health	Within own delegated budget	Up to £300k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of W & OD	Within own delegated budget	Up to £300k						Up to £100k	Terminations up to £50k (>£50k = WG)					Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Nursing & Midwifery	Within own delegated budget	Up to £300k						Up to £100k	Up to £150k					Can approve new posts within own structure.	Must approve in advance in own structure.
Executive Director of Therapies & Health Sciences	Within own delegated budget	Up to £300k			Up to £150k			Up to £100k	Up to £150k					Can approve new posts within own structure.	Must approve in advance in own structure.
Director of Digital & CDIO	Within own delegated budget	Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure

	Budget changes	General expenditure	Healthcare agreements	Revenue and Capital (Business Case and Contractual Commitment approvals)			Specialist				Charitable Funds		Procurement waivers	Staffing	
	Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.														
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishment)	Agency and Waiting List Initiatives (all values)
Director of Partnerships, Engagement & Communications	Within own delegated budget	Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure
Board Secretary	Within own delegated budget	Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.
Other Directors (or Associate Directors)	Within own delegated budget	Up to £250k						Up to £100k						Can approve new posts within own structure.	Must approve in advance in own structure.

	Budget changes	General expenditure	Healthcare agreements	Capital			Specialist				Charitable Funds		Procurement waivers	Staffing	
		Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.													
	Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
Regional Directors / Systems Oversight Directors	Within own delegated budgets	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Integrated Health Care Directors , Health Community Director of Operations, Director of Mental Health & Learning Disabilities	Within own delegated budget	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k			Can approve new posts within own team.	As escalated by Direct Reports*
Associate Directors	Within own delegated budget	Up to £150k			Up to £150k			Up to £150k			Up to £5k			Can approve new posts within own structure	Must approve in advance in own structure.
Assistant Directors	Within own delegated budget	Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k			Can approve new posts within own structure	Must approve in advance in own structure.
Head of Investigations and Redress									Up to £20k					Can approve new posts within own structure	
Claims Managers									Up to £5k						
Authorised fund holder (Charitable Funds)											Up to £5k				
Medicines Management Group(s)										All new drugs and treatments					
* Agency and Waiting List Initiatives must generally be approved in advance. However, in exceptional circumstances when staff are required out of hours, they can be approved retrospectively.															

This scheme only relates to matters delegated by the Board to the Chief Executive and Directors, together with certain other specific matters referred to in Standing Financial Instructions. Each Director is responsible for delegation within their department, in line with Table B2 below.

Table B.2 – Scheme of Financial Delegation, Divisional Level Posts

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	**General expenditure**	**Healthcare agreements**	**Capital (Business Case and Contractual Commitment approvals)**			**Specialist**				**Charitable Funds**		**Procurement waivers**	**Staffing**	
	Budget Virements (cross-divisional virements need appropriate reciprocal approval)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values (authorised within local Delegation but ultimate Approval is with the DoF)	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
IHC Director MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med Mgt Group	Up to £5k		Up to £250k	Within Delegated Budget.	Within Delegated Budget
Director of Operations, MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £250k	New or contract variation to £1.5m		Up to £250k			Up to £100k		Up to £100k, following Med MGT Group	Up to £5k		Up to £250k	Within Delegated Budget.	Within Delegated Budget
CFO / FD "note1"	Within Budget	Up to £200k	Up to £200k		Up to £200k			Up to £80k			Up to £5k		Up to £250k	Within Delegated Budget	Within Delegated Budget
Director: Nursing MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k			Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Director: 'Doctor' MHL and Pan-BCU equivalent	Up to the Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k		Up to £100k, following Med MGT Group	Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Head of Medicines Mgt	Up to Delegated Budget limit	Up to £150k (within Meds Mgt)	Up to £150k (within Meds Mgt)		Up to £150k			Up to £75k		Up to £100k, following Med Mgt Group	Up to £5k		Up to £75k	Within own Delegated Budget.	Within own Delegated Budget

Table B.2 – Scheme of Financial Delegation, Divisional Level Posts

Any expenditure approval must be within funding limits of approved budgets.
Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.
Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.

	Budget changes	**General expenditure**	**Healthcare agreements**	**Capital (Business Case and Contractual Commitment approvals)**			**Specialist**				**Charitable Funds**		**Procurement waivers**	**Staffing**	
	Budget Virements (cross-divisional virements need appropriate reciprocal approval)	Individual orders / requisitions / annual order value or total contract value (unless otherwise noted)	Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board)	Building and engineering orders; related consultancy support(individual contractual commitment)	Medical devices; plant; machinery; related consultancy support(individual contractual commitment)	IM&T; telecoms systems; software; related consultancy (individual contractual commitment)	Property or equipment leases(granting or termination of leases; annual value)	External consultancy support (total contract value for duration of service)	Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee)	New drugs (value based on annual costs)	Locally held funds(total funding bid value)	General funds(total funding bid value)	All values (authorised within local Delegation but ultimate Approval is with the DoF)	New posts (additional establishm't)	Agency and Waiting List Initiatives (all values)
Head of Therapies	Up to Delegated Budget limit	Up to £150k (within Therapies)	Up to £150k (Within Therapies)		Up to £150k			Up to £75k			Up to £5k		Up to £75k	Within own Delegated Budget.	Within own Delegated Budget
Deputy Director (equivalent)	Up to Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k			Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Associate Directors (equivalent)	Up to Delegated Budget limit	Up to £150k	Up to £150k		Up to £150k			Up to £75k			Up to £5k		Up to £150k	Within own Delegated Budget.	Within own Delegated Budget
Assistant Directors (equivalent)	Up to Delegated Budget limit	Up to £75k	Up to £75k		Up to £75k			Up to £75k			Up to £5k		Up to £75k	Within own Delegated Budget.	Within own Delegated Budget
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****NOTES****

1. The CFO / FD (Job Title to be defied within the New OM) is a key role within the Financial Governance arrangements, however their role is to "review" and "ratify" Oracle Requisitions, Contracts, Establishment Control Requests, and other such financial instruments within the limits of their particular IHC / Division, not to "approve" them; Approval sits with the delegated Budget Manager. As such their financial limit within Oracle will technically be set at £0, to reflect this context. There may be specific items or instances where the CFO/FD does need to "approve" and these will be listed separately.